

Board Meeting

Board Meeting - July 15, 2026

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Mission

Northern Inyo Healthcare District provides health care services to improve the quality of life and health for all we serve

Vision

Northern Inyo Healthcare District will be known throughout the Eastern Sierra Region for providing high quality, compassionate, comprehensive care in coordination with regional partners.

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT BOARD OF DIRECTORS REGULAR MEETING

July 15, 2026, 3:30 pm

Open Session scheduled to begin at 5:00 pm

The Board meets in person at 2957 Birch Street, Bishop, CA 93514. Members of the public will be allowed to attend in person or via Zoom. Public comments can be made in person or via Zoom.

TO CONNECT VIA ZOOM: (A link is also available on the NIHD Website)

<https://us06web.zoom.us/j/86114057527>

Webinar ID: 861 1405 7527

Passcode: 898843

PHONE CONNECTION:

(669) 444-9171

(719) 359-4580

Webinar ID: 861 1405 7527

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1. Call to order at 3:30 pm
 2. Public comment on closed session items
 3. Adjournment to closed session for:
 - a. Conference with Legal Counsel: Initiation of Litigation
Pursuant to Government Code § 54956.9(d)(4)
Number of Potential Cases: 1
 - Open Session Scheduled to begin at 5:00 pm**
 4. Return to open session and report on any actions taken in closed session.
 5. Pledge of Allegiance
 6. Public Comment: The purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are limited to three (3) minutes per speaker, with a total time limit of thirty (30) minutes for all public comments unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be

kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered.

7. Consent Agenda – All matters listed under the consent agenda are considered routine and will be enacted by one motion unless any member of the Board wishes to remove an item for discussion.
 - a. Approval of minutes for June 17, 2026 Regular Board Meeting
 - b. Approval of Policies and Procedures
 - i. California Public Records Act – Information Requests
 - ii. Compliance Program for Northern Inyo Healthcare District
 - iii. Governmental and Regulatory Agency Access Policy
 - iv. Just Culture Policy
 - v. Language Access Services
 - vi. Record Retention and Destruction Policy
 - vii. Sanctions for Breach of Patient Privacy Policies
 - viii. Service and Therapy Animals and Pets in District Buildings
 - ix. Standardized Protocol – Minor Surgical Policy for the Physician Assistant
8. Consideration of Credentialing Actions recommended by the Medical Executive Committee – Action Item
 - a. Medical Staff Initial Appointments 2026-2027
9. Medical Staff Officers 2026-2027 – Action Item
10. Medical Staff Bylaw Amendments – Action Item
11. Resolution 26-02 Finding of Exemption from Appropriations Limit – Action Item
12. Resolution 26-03 Requesting the Levy of Tax on the Taxable Property of the District to Be Collected on the Tax Rolls of the County of Inyo for Fiscal Year 2026-27 – Action Item
13. Chief Operation Officer / Chief Nursing Officer Report
 - a. Capital Update – Information Item
 - b. Inpatient Dialysis – Information Item
14. Finance Committee
 - a. Strategic Growth, Wipfli/WOLD Update – Information Item
 - b. RHTP – Information Item
 - c. Tele-nephrology Equipment Update – Information Item
 - d. Grant Update
 - i. Telemedicine Equipment (USDA) – Information Item
 - e. Financial and Statistical Report – Action Item

15. Governance Committee

- a. Advocacy Update – Information Item
- b. Media Policy – Action Item

16. General Information from Board Members

17. Adjournment

In compliance with the Americans with Disabilities Act, if you require special accommodations to participate in a District Board meeting, please contact the administration at (760) 873-2838 at least 24 hours before the meeting.

CALL TO ORDER	Northern Inyo Healthcare District (NIHD) Board Vice-Chair Lent called the meeting to order at 4:15 pm.
PRESENT	David Lent, Vice-Chair Maggie Egan, Secretary Jean Turner, Member at Large Christian Wallis, Chief Executive Officer Allison Partridge, Chief Operations Officer / Chief Nursing Officer Alison Murray, Chief Human Resources Officer, Chief Business Development Officer Andrea Mossman, Chief Financial Officer
ABSENT	Melissa Best-Baker, Chair Laura Smith, Treasurer Adam Hawkins, Chief Medical Officer
TELECONFERENCING	Notice has been posted, and a quorum participated from locations within the jurisdiction.
PUBLIC COMMENT ON CLOSED SESSION ITEMS	Vice-Chair Lent reported that at this time, audience members may speak only on closed session agenda items. Public Comment: None
ADJOURN TO CLOSED SESSION	Adjourn to closed session at 4:17 pm.
RETURN TO OPEN SESSION	Return to open session at 5:23 pm.
REPORT OUT FROM CLOSED SESSION	No reportable action
PUBLIC COMMENT	Vice-Chair Lent reported that at this time, audience members may speak on any items not on the agenda that are within the jurisdiction of the Board. Public Comment: None
CONSENT AGENDA	Public Comment: None Board Discussion: None Motion by Turner to approve the consent agenda. 2nd: Egan Pass: 3-0
CONSIDERATION OF CREDENTIALING	Public Comment: None

ACTIONS
RECOMMENDED BY THE
MEDICAL EXECUTIVE
COMMITTEE

Board Discussion: None

Motion by Turner to approve the credentialing actions recommended by the Medical Executive Committee

2nd: Egan

Pass: 3-0

MEDICAL STAFF
BYLAWS

MEC Chair Dr. Jeppsen presented proposed amendments to the Medical Staff Bylaws, including revisions intended to expand physician representation on the Medical Executive Committee. Dr. Jeppsen explained that one proposed amendment would establish separate positions for the Chiefs of Anesthesia, Orthopedics, and Surgery to increase surgical representation. She noted that while the Medical Executive Committee had hoped to implement the changes in July, delaying action until August would not create a significant operational impact.

Public Comment: None

Board Discussion:

Board members discussed the proposed amendments and the importance of conducting a thorough review of the Medical Staff Bylaws before taking action. One Board member expressed that approval of the amendments also represented approval of the bylaws as a whole and requested additional time to review the document

Motion by Egan to bring the Medical Staff Bylaw amendments to the July 2026 meeting.

2nd: Turner

Pass: 3-0

CEO REPORT

Auxiliary Report

Auxiliary representatives Giansetto and Fratella provided an update on Auxiliary activities and volunteer efforts. They reported preparations for the annual holiday boutique, ongoing recruitment of new members through community outreach, and participation in local events to increase awareness of the Auxiliary. They also reported that volunteers contributed 6,882 service hours during the past year, an increase of more than 2,000 hours over the previous year, bringing the organization's cumulative volunteer service to 316,918 hours since 1988. Representatives announced plans to raffle a handmade quilt during the upcoming holiday boutique in addition to the annual \$1,000 raffle. Hospital leadership recognized the Auxiliary's longstanding support of the District through annual donations for capital equipment and committed to providing a list of equipment funding requests for the Auxiliary's July meeting.

Public Comment: None

Board Discussion:

Board members commended the Auxiliary for its outstanding volunteer service and discussed the organization's ability to foster long-term member engagement and a welcoming volunteer culture. The Board expressed appreciation for the Auxiliary's continued dedication and its lasting contributions to the District and the community.

Foundation Report

Foundation Board Member Watercott presented an update on Foundation activities and fundraising efforts. He reported that the Foundation established an annual fundraising goal of \$250,000 and continues to explore sustainable fundraising opportunities following previous signature events. He highlighted the recent Bunco fundraiser, which generated approximately \$2,000 in net proceeds while providing strong community participation. He also reported that the Foundation contributed more than \$2,000 toward the stereotactic mammography machine and more than \$3,000 toward improvements to the Healing Garden, and noted that the Foundation will celebrate the 10th anniversary of the CARE Shuttle in August.

Public Comment: None

Board Discussion:

Board members discussed potential fundraising opportunities, including the use of a silent auction in conjunction with future fundraising events. Appreciation was expressed for the Foundation's ongoing efforts to support the District through fundraising and community engagement.

NIH Bishop Housing

CHRO Murray presented an overview of the District's workforce housing needs and the operational benefits of securing ten units in the proposed Bishop Commons workforce housing development. She explained that housing continues to be a significant recruitment and retention challenge, particularly for traveling healthcare professionals and newly hired permanent employees who often require temporary housing while relocating to the area. She noted that the proposed one-bedroom units would provide appropriate accommodations for single occupants, allowing larger single-family homes to remain available for families relocating to the community. She also reported that the District continues to utilize Joseph House and local motels to meet workforce housing needs, but demand continues to exceed available resources.

Public Comment: None

Board Discussion:

Board members discussed the District's current workforce housing resources, including the use of Joseph House and local motels, and expressed support for the proposed workforce housing units as a means of improving recruitment while preserving larger homes for families.

Bishop Commons Worker Housing Memorandum of Understanding

CEO Wallis presented a proposed non-binding Memorandum of Understanding (MOU) with Foothill Partners regarding the District's interest in reserving ten workforce housing units within the proposed Bishop Commons development. He explained that the MOU would demonstrate the District's interest in the project and assist Foothill Partners in securing project financing, while creating no binding obligation for the District. Legal counsel reported that the MOU had been reviewed and determined to be a standard, non-binding agreement.

Public Comment: None

Board Discussion:

Board members discussed the omission of the MOU from the meeting packet and options for proceeding with the request. Following discussion and confirmation from legal counsel regarding the agreement's non-binding nature, the Board approved the MOU contingent upon review by the participating Board members prior to execution.

Motion by Turner to approve the Bishop Commons Worker Housing MOU contingent on no challenges by June 30, 2026

2nd: Egan

Pass: 3-0

Strategic Growth, Wipfli/WOLD

CEO Wallis provided a strategic growth update on the District's ongoing master facility planning and Medical Office Building (MOB) project. He reported that planning continues on the proposed MOB while the District is also pursuing renovations to the PMA Building to address immediate space constraints for physicians and specialists. The proposed PMA redesign would increase exam room capacity from 17 to 32 rooms while incorporating a more efficient team-based layout designed to support future conversion of the building to administrative space. He also reported that Dr. Reed's office would be relocated to allow phased construction and that the City approved consolidating the Reed property with the existing campus, creating a single site for future development of the Medical Office Building.

Public Comment: None

Board Discussion: Board members expressed support for the progress made on the District's strategic growth initiatives and discussed the importance of communicating the purpose and long-term value of the facility improvements to the community.

Opening Meeting Routine

CEO Wallis presented a request to reconsider the Board's opening meeting routine following a Board member's request to return the item for further

discussion. It was noted that the Board had previously agreed to retain the Mission and Vision Statement as part of the agenda and that the current action item pertained only to adding the Pledge of Allegiance to the beginning of regular Board meetings.

Public Comment: None

Board Discussion:

Board members discussed adding the Pledge of Allegiance to the opening meeting routine while emphasizing the importance of maintaining the Board's nonpartisan role.

Motion by Turner to add the pledge of allegiance to the opening meeting routine

2nd: Egan

Pass: 3-0

CHRO

Retirement Accounts

USI Consulting Group Partner and Vice President Herskowitz presented the annual actuarial valuation of the District's retirement plan and provided an overview of the plan's funding status, investment performance, and employer contribution requirements. He reported that the pension plan's funded status has increased from approximately 15% in 2020–2021 to 45%, reflecting the District's ongoing commitment to funding the plan and implementing improved governance practices. He also noted that pension assets have grown from approximately \$10–11 million to nearly \$26 million, supported by consistent employer contributions and investment performance. He commended District leadership, Human Resources, Finance, and the Pension Committee for their continued commitment to strengthening the retirement program.

Public Comment: None

Board Discussion:

Board members acknowledged the significant progress made in improving the pension plan's funded status and expressed appreciation for the efforts of District leadership and staff in strengthening the retirement program.

CFO REPORT

Financial and Statistical Report

CFO Mossman presented the April Financial and Statistical Report. She explained that April operating results reflected a one-time accounting correction to reverse a duplicate revenue entry from the District's electronic health record system, resulting in a temporary negative impact to the month's operating income, while underlying operating performance continued to exceed revenue expectations. She reported continued growth in orthopedic and surgical service volumes, a \$5 million increase in cash during the fiscal year, and improvements in accounts receivable, with collection times reduced by 19 days compared to the prior year. She also reported that days cash on hand increased to 103 days, unrestricted funds grew to \$34 million, and bond covenant requirements

continued to exceed minimum thresholds. She concluded by highlighting ongoing initiatives to improve operating room utilization, service line growth, revenue cycle performance, and financial benchmarking, expressing confidence that the District remains on track to end the fiscal year with strong financial results.

Public Comment: None

Board Discussion:

Board members discussed the April financial results, including the impact of the one-time accounting correction, and expressed appreciation for the District's continued financial improvement and the Finance Department's efforts.

Motion by Egan to accept the Financial and Statistical Report

2nd: Turner

Pass: 3-0

GENERAL INFORMATION
FROM BOARD MEMBERS

Board members expressed appreciation for the continued contributions of the Auxiliary and Foundation and requested formal recognition of Auxiliary members for their longstanding volunteer service to the District. Members also highlighted community recognition received during Mule Days, including acknowledgment of the hospital's nearly 80 years of service to the Eastern Sierra and recognition of Chief Executive Officer Wallis by Senator Alvarado-Gil for his leadership and contributions to healthcare and the community.

ADJOURNMENT

Adjournment at 6:36 pm.

Melissa Best-Baker
Northern Inyo Healthcare District
Chair

Attest: _____
Maggie Egan
Northern Inyo Healthcare District
Secretary



NORTHERN INYO HEALTHCARE DISTRICT NON-CLINICAL POLICY AND PROCEDURE

Title: California Public Records Act – Information Requests		
Owner: Compliance Officer	Department: Compliance	
Scope: District-wide		
Date Last Modified: 05/29/2026	Last Review Date: No Last Periodic Review Date Set	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 01/19/2016	

PURPOSE:

This policy establishes procedures for responding to requests for public records maintained by Northern Inyo Healthcare District (“NIHD” or “District”) in accordance with the California Public Records Act (“CPRA”), California Government Code §§ 7920.000 et seq., while protecting records exempt from disclosure under state and federal law.

NIHD is committed to transparency and compliance with applicable public access laws while safeguarding confidential, privileged, protected health information, peer review records, cybersecurity information, and other protected records.

DEFINITIONS:

California Public Records Act (CPRA)

California laws governing public access to governmental records, codified at California Government Code §§ 7920.000 et seq.

Public Record

Any writing relating to the conduct of the public's business that is prepared, owned, used, or retained by NIHD, regardless of physical form or characteristics.

Writing

Includes handwriting, typewriting, printing, photostating, photographing, photocopying, transmitting by electronic mail or facsimile, and every other means of recording information.

Electronic Record

Any record stored electronically, including emails, text messages, databases, spreadsheets, electronic documents, audio files, video files, metadata, and electronically stored information (“ESI”).

Protected Health Information (PHI)

Individually identifiable health information protected under HIPAA, the California Confidentiality of Medical Information Act (“CMIA”), and other applicable laws.

Exempt Record

A record exempt from disclosure under federal or state law, including privileged, confidential, or protected records.

POLICY:

All requests for records under the California Public Records Act shall be referred to the Compliance Officer or designee for review, coordination, and response.

Requests directed to the Board of Directors shall be processed in accordance with this policy and any applicable Board policies governing public records requests.

The Compliance Officer serves as the Custodian of Business Records and CPRA Coordinator. Requests involving medical records shall be coordinated with the Health Information Management Department and the Custodian of Medical Records, as appropriate.

PROCEDURE:

1. EXEMPTIONS FROM DISCLOSURE

The following categories of records are generally exempt from disclosure, to the extent permitted by applicable law:

- Medical records and Protected Health Information (PHI);
- Peer review records and proceedings;
- Medical Staff credentialing and privileging records;
- Quality improvement, patient safety, utilization review, and performance improvement records protected by law;
- Records protected by attorney-client privilege, attorney work product doctrine, or other legally recognized privileges;
- Personnel records where disclosure would constitute an unwarranted invasion of privacy;
- Security, cybersecurity, vulnerability assessment, and emergency preparedness records;
- Records protected by HIPAA, CMIA, 42 CFR Part 2, the Evidence Code, Health and Safety Code, Welfare and Institutions Code, or other applicable federal or state law.

2. CPRA COORDINATOR RESPONSIBILITIES

The Compliance Officer serves as the District's CPRA Coordinator and is responsible for coordinating record searches, legal review, redaction, production, exemption determinations, and communications with requesters.

3. REQUEST PROCESSING

- a. Public records requests should be submitted to the Compliance Office. The Compliance Officer serves as the District's CPRA Coordinator and may consult with Legal Counsel regarding exemption determinations, redactions, privilege claims, litigation considerations, complex requests, or other matters involving uncertain disclosure obligations.
- b. Public records may include emails, text messages, instant messages, and other electronic communications relating to District business, regardless of whether such communications are

created, transmitted, or maintained on District-owned or personal devices or accounts, to the extent required by applicable law.

- c. Within 10 calendar days of receiving a request, NIHD will determine whether responsive records exist and whether they are subject to disclosure. This period may be extended as permitted by law for voluminous or complex requests. NIHD will notify the requester of its determination and provide a good-faith estimate of when responsive records will be available.
- d. NIHD will assist members of the public in making focused and effective requests that reasonably describe identifiable records.
- e. NIHD may not consider the identity of the requester or the purpose of the request when determining whether records are subject to disclosure. Requests submitted by current employees shall be processed in the same manner as requests submitted by any other member of the public, except where separate statutory rights or procedures apply.
- f. NIHD is not required to create new records, answer questions, or prepare summaries in response to a request. However, NIHD will provide access to existing records and extract data from existing databases when required by law.
- g. Prior to production, records shall be reviewed for responsiveness, applicable legal holds, litigation preservation requirements, confidentiality obligations, privileges, and statutory exemptions. The District may review and redact records before disclosure.
- h. Nothing in this policy requires disclosure of records made confidential by federal or state law. When a record contains both disclosable and exempt information, NIHD will redact exempt information and disclose the remainder when reasonably segregable.
- i. Where appropriate, records may be produced on a rolling basis as records are identified, collected, reviewed, and redacted.
- j. Public records are available for inspection during normal business hours. Immediate access is not required, as records may need to be identified, collected, reviewed, and prepared for inspection.
- k. The District may require an appointment for record inspection. Additional appointments may be required for large or complex requests.
- l. Persons inspecting records shall not remove, alter, destroy, mutilate, deface, or otherwise damage District records. NIHD may require District personnel to be present during inspections to protect records and maintain their integrity.
- m. Upon completion of the inspection, or upon request of District personnel, the requester shall relinquish possession of all records made available for inspection.
- n. The operational functions of the District shall not be suspended or disrupted to accommodate record inspections.

- o. The District may charge the direct cost of duplication as permitted by applicable law. Fees for electronic records shall be assessed only as authorized by the California Public Records Act. Payment may be required before records are released.
- p. If a request involves Medical Staff records, credentialing records, privileging records, peer review records, or records relating to physicians or advanced practice providers, the Compliance Officer shall coordinate review with the Medical Staff Office, Legal Counsel, and other appropriate personnel.

REFERENCES:

1. California Public Records Act, Government Code §§ 7920.000 et seq.
2. Ralph M. Brown Act, Government Code §§ 54950 et seq.
3. Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160 and 164.
4. California Confidentiality of Medical Information Act (CMIA), Civil Code §§ 56 et seq.
5. California Evidence Code provisions relating to privilege.
6. California Health and Safety Code provisions relating to peer review and quality records.
7. City of San Jose v. Superior Court (2017) 2 Cal.5th 608
8. California Attorney General Open Government Resources
9. 42 CFR Part 2 – Confidentiality of Substance Use Disorder Patient Records.

RECORD RETENTION AND DESTRUCTION:

Record retention requirements vary based on the document type, legal, and accreditation requirements.

Destruction of potentially responsive records shall be suspended upon receipt of a public records request, litigation hold, subpoena, audit notice, governmental investigation, or other legal preservation requirement.

CROSS-REFERENCED POLICIES AND PROCEDURES:

1. Compliance Program for Northern Inyo Healthcare District
2. Public Records Requests (Board of Directors)

Supersedes: v.4 California Public Records Act – Information Requests
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NORTHERN INYO HEALTHCARE DISTRICT

ANNUAL PLAN

Title: Compliance Program for Northern Inyo Healthcare District		
Owner: Compliance Officer	Department: Compliance	
Scope: District-wide		
Date Last Modified: 06/10/2026	Last Review Date: No Last Periodic Review Date Set	Version: 6
Final Approval by: NIHD Board of Directors	Original Approval Date: 11/18/2016	

I. PURPOSE

Northern Inyo Healthcare District (NIHD or “District”) is committed to conducting all operations ethically, lawfully, and in a manner that protects patients, workforce members, public resources, and the integrity of the healthcare system.

This Compliance Program establishes the framework used by NIHD to:

- Promote ethical conduct
- Prevent fraud, waste, abuse, and misconduct
- Ensure compliance with applicable laws and regulations
- Protect patient rights and privacy
- Encourage reporting of concerns without fear of retaliation
- Support safe, high-quality patient care

This Program applies to all:

- Board members
- Employees
- Medical staff
- Contractors
- Volunteers
- Students
- Vendors and business partners performing services for NIHD

II. REGULATORY FRAMEWORK

This Program is based on applicable federal and California laws and guidance, including:

- OIG General Compliance Program Guidance (2023)
- CMS Conditions of Participation for Critical Access Hospitals
- HIPAA and HITECH
- EMTALA
- False Claims Act
- Anti-Kickback Statute
- Stark Law
- Section 1557 of the Affordable Care Act

- California Confidentiality of Medical Information Act (CMIA)
- California Health & Safety Code
- California Public Records Act (CPRA)
- Brown Act
- Joint Commission standards
- CDPH requirements
- HCAI requirements

III. COMPLIANCE PROGRAM PRINCIPLES

NIHD maintains a compliance program based on the seven elements recognized by the Office of Inspector General (OIG):

1. Written policies and standards of conduct
2. Compliance leadership and oversight
3. Education and training
4. Effective communication and reporting
5. Monitoring and auditing
6. Enforcement and accountability
7. Investigation and corrective action

IV. STANDARDS OF CONDUCT

All workforce members are expected to:

- Act honestly and ethically
- Follow applicable laws and District policies
- Treat patients, visitors, and coworkers respectfully
- Protect patient privacy and confidential information
- Report concerns in good faith
- Avoid conflicts of interest
- Support accurate documentation and billing

NIHD prohibits:

- Fraudulent billing or documentation
- Retaliation against good-faith reporters
- Discrimination or harassment
- Improper access to protected information
- Improper gifts or inducements
- Falsification of records
- Violations of patient rights

All workforce members are responsible for maintaining a professional, respectful, and legally compliant workplace.

V. GOVERNANCE AND OVERSIGHT

A. Board of Directors

The Board of Directors is responsible for oversight of the Compliance Program.

The Board shall:

- Receive regular compliance reports
- Review significant compliance risks
- Support adequate compliance resources
- Oversee program effectiveness
- Ensure appropriate corrective actions are taken

The Compliance Officer shall report to the Board no less than quarterly.

B. Compliance Officer

NIHD shall maintain a Compliance Officer with authority to oversee and administer the Compliance Program.

The Compliance Officer shall have direct access to:

- Chief Executive Officer
- Governing Board
- Legal counsel, as appropriate

Responsibilities include:

- Program oversight
- Investigations
- Training coordination
- Auditing and monitoring
- Risk assessments
- Policy oversight
- Regulatory tracking
- Board reporting
- Corrective action oversight

The Compliance Officer has authority to review records and information necessary to perform compliance responsibilities.

C. Compliance Committee

NIHD shall maintain a multidisciplinary Compliance Committee to support the Compliance Program.

The Committee may include representatives from:

- Compliance
- Quality
- Nursing
- Medical Staff
- Finance
- Revenue Cycle
- Human Resources
- Information Technology
- Health Information Management
- Operations
- Security
- Risk Management

The Committee assists with:

- Risk assessment
- Work plan development
- Audit review
- Corrective action monitoring
- Education planning
- Regulatory readiness

VI. EDUCATION AND TRAINING

NIHD shall provide compliance education and training appropriate to workforce roles and responsibilities.

Training topics may include:

- Compliance Program and Code of Conduct
- HIPAA Privacy and Security
- Cybersecurity awareness
- EMTALA
- Patient rights and grievances
- Language access services
- Fraud, waste, and abuse prevention
- Billing and documentation requirements
- Workplace conduct
- Non-retaliation

Training shall occur:

- During orientation
- Annually, as required
- When regulations or operational risks change
- As part of corrective action efforts

Completion of required training is a condition of continued employment or engagement.

VII. REPORTING CONCERNS

NIHD encourages workforce members to report concerns, suspected misconduct, or potential violations.

Concerns may be reported through:

- Supervisors
- Compliance Officer
- Human Resources
- Compliance hotline
- ~~Written or electronic reporting methods~~ Unusual Occurrence Reporting System

Reports may be made anonymously where permitted.

NIHD prohibits retaliation against individuals who report concerns in good faith.

False or intentionally misleading reports may result in corrective action.

VIII. AUDITING AND MONITORING

NIHD shall maintain a risk-based auditing and monitoring program.

Audits and reviews may include:

- Billing and coding
- Medical necessity
- Documentation accuracy
- HIPAA access monitoring
- EMTALA compliance
- Patient rights and grievances
- Language access compliance
- Cybersecurity controls
- Vendor compliance
- Contract oversight
- Exclusion screening
- Quality and patient safety concerns

Audit findings shall be reviewed and tracked for corrective action.

IX. ENTERPRISE RISK ASSESSMENT

NIHD shall conduct an annual compliance risk assessment.

The assessment may consider:

- OIG work plan priorities
- CMS and CDPH findings
- Joint Commission findings
- HIPAA/security incidents
- Patient complaints and grievances
- Billing and coding risks
- Cybersecurity threats
- Operational changes
- Vendor and technology risks
- Internal audit findings

The Compliance Officer shall maintain an annual Compliance Work Plan based on identified risks.

X. INVESTIGATIONS AND CORRECTIVE ACTION

NIHD shall promptly investigate reports of suspected misconduct or noncompliance.

Investigations may involve:

- Interviews
- Record reviews
- Audit activity

- Legal review
- External experts, as appropriate

Where issues are identified, NIHD may implement corrective actions including:

- Education
- Policy revision
- Process improvement
- Monitoring
- Repayment obligations
- Discipline
- Reporting to regulatory agencies when required

Investigation and corrective action records shall be maintained in accordance with District policy and legal requirements.

XI. DISCIPLINE AND ACCOUNTABILITY

Failure to comply with laws, regulations, District policies, or this Compliance Program may result in corrective action up to and including:

- Counseling
- Retraining
- Suspension
- Termination
- Contract termination
- Reporting to licensing or regulatory agencies

Leaders may be subject to corrective action for failing to:

- Promote compliance
- Address known issues
- Monitor high-risk activities
- Enforce District standards

XII. PRIVACY, SECURITY, AND CYBERSECURITY

NIHD is committed to protecting protected health information (PHI), confidential information, and District systems.

NIHD shall maintain safeguards including:

- Access controls
- Audit logging
- Password and authentication standards
- Security risk assessments
- Workforce cybersecurity training
- Device and mobile security controls
- Vendor security reviews
- Incident response procedures
- HIPAA/[CMIA](#) breach response processes

Unauthorized access, use, or disclosure of information may result in disciplinary action.

XIII. ARTIFICIAL INTELLIGENCE (AI) AND TECHNOLOGY GOVERNANCE

NIHD recognizes emerging risks related to artificial intelligence and automated technologies.

Use of AI tools must:

- Be approved by NIHD
- Protect patient privacy
- Comply with HIPAA and security requirements
- Include appropriate human oversight
- Be used only within approved operational or clinical workflows

AI tools shall not replace required:

- Clinical judgment
- Informed consent discussions
- Qualified interpreter services where required
- Documentation review responsibilities

The District may prohibit or restrict AI tools that create operational, privacy, security, patient safety, or regulatory risks.

XIV. LANGUAGE ACCESS AND NON-DISCRIMINATION

NIHD shall provide meaningful access to care and services consistent with:

- Section 1557
- ADA requirements
- CMS Conditions of Participation
- Joint Commission standards

NIHD shall maintain:

- Qualified interpreter services
- Processes for bilingual employee qualification
- Auxiliary aids and services
- Non-discrimination protections
- Appropriate documentation standards

Patients may decline interpreter services; however, NIHD remains responsible for ensuring effective communication.

XV. PATIENT RIGHTS AND GRIEVANCES

NIHD is committed to protecting patient rights and responding appropriately to complaints and grievances.

The District shall maintain processes for:

- Receiving complaints and grievances
- Timely review and investigation
- Written grievance responses when required
- Escalation of quality or patient safety concerns

- Tracking and trending concerns

Complaint and grievance data may be reviewed for quality, compliance, and patient safety improvement efforts.

XVI. BILLING, CODING, AND REVENUE INTEGRITY

NIHD shall submit claims that are:

- Accurate
- Supported by documentation
- Medically necessary
- Compliant with applicable payer requirements

NIHD prohibits:

- False claims
- Improper coding
- Misrepresentation of services
- Improper inducements
- Billing for services not provided

The District shall maintain oversight processes for:

- Coding accuracy
- Documentation integrity
- Overpayment identification and repayment
- Physician arrangements
- Charity care and financial assistance compliance
- Price transparency requirements

XVII. CONFLICTS OF INTEREST

Workforce members shall avoid actual or perceived conflicts of interest.

Potential conflicts may include:

- Financial relationships
- [Family relationships](#)
- [Vendor relationships](#)
- Outside employment
- Purchasing influence
- Referral-related concerns

Workforce members shall disclose potential conflicts according to District policy.

NIHD may require:

- Management plans
- Recusal from decision-making
- Additional oversight
- Elimination of the conflict

XVIII. EXCLUSION SCREENING

NIHD shall conduct exclusion screening of employees, providers, contractors, and vendors against applicable federal and state exclusion databases.

Individuals or entities excluded from participation in federal healthcare programs may not perform services prohibited by law.

XIX. RECORDS RETENTION

Compliance-related records shall be maintained according to:

- Federal requirements
- California law
- District policy

Records may include:

- Audit documentation
- Investigation files
- Training records
- Compliance reports
- Corrective action plans
- Hotline records

XX. PROGRAM EFFECTIVENESS

The Compliance Officer shall periodically evaluate the effectiveness of the Compliance Program.

Program evaluation may include review of:

- Audit results
- Hotline activity
- Investigation trends
- Training completion
- Corrective action completion
- Regulatory findings
- Patient complaints and grievances
- Security incidents
- Leadership engagement

The Compliance Program shall be reviewed at least annually and updated as needed.

XXI. RELATED POLICIES

NIHD maintains supporting compliance-related policies and procedures, including but not limited to:

- HIPAA Privacy and Security
- EMTALA
- Language Access Services
- Non-Retaliation
- Patient Rights
- Cybersecurity

- Vendor Management
- Billing and Coding
- Conflict of Interest
- Public Records Requests
- Accessibility Compliance
- Incident Reporting
- Grievance Management
- Records Retention

XXII. APPROVAL

This Compliance Program is effective upon approval by the NIHD Board of Directors and supersedes prior versions of the NIHD Compliance Program.

The Program shall be reviewed annually and revised as necessary to reflect operational, legal, regulatory, and organizational changes.

REFERENCES:

1. [Supplemental Compliance Program Guidance for Hospitals](#) (70 Fed. Reg. 4858; January 31, 2005)
2. [Compliance Program Guidance for Hospitals](#) (63 Fed. Reg. 8987; February 23, 1998)

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Authority of the Chief Executive Officer for Contracts and Bidding
2. Business Associate Agreements Execution and Management
3. California Public Records Act – Information Requests
4. Communicating Protected Health Information via Electronic Mail (Email)
5. Disclosures of Protected Health Information Over the Telephone
6. Disposal of Equipment
7. Electronic Communication (Email) Acceptable Use Policy
8. False Claims Act Employee Training and Prevention Policy
9. Family Member and Relatives in the Workplace
10. Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information
11. Language Access Services Policy
12. NIHD Code of Business Ethics and Conduct
13. Non-Retaliation Policy
14. Nondiscrimination Policy
15. Patient Rights
16. Pricing Transparency Policy
17. Purchasing Signature Authority
18. Equal Employment Opportunity
19. Sanctions for Breach of Patient Privacy Policies
20. Sending Protected Health Information via Fax
21. Using and Disclosing Protected Health Information for Treatment, Payment and HealthCare Operations
22. Vendor Credentialing
23. Workforce Access to His or Her Own Protected Health Information
24. Workforce Investigations
25. InQuiseek – #100 Regulatory Compliance Policy
26. InQuiseek - #105 Formal Corporate or Organization Compliance Plan Policy

Supersedes: v.5 Compliance Program for Northern Inyo Healthcare District
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NORTHERN INYO HEALTHCARE DISTRICT NON-CLINICAL PROCEDURE

Title: Governmental and Regulatory Agency Access Policy		
Owner: Compliance Officer	Department: Compliance	
Scope: District-wide		
Date Last Modified: 06/30/2026	Last Review Date: No Last Periodic Review Date Set	Version: 5
Final Approval by: Board of Directors, NIHD	Original Approval Date: 05/20/2014	

PURPOSE:

Northern Inyo Healthcare District (“NIHD”) maintains procedures for verifying, coordinating, and managing access by governmental representatives, regulatory surveyors, investigators, and other authorized external agency personnel in a manner that protects patient rights, privacy, safety, security, and regulatory compliance obligations.

This policy establishes requirements for identification verification, escort procedures, access limitations, and communication protocols for governmental and regulatory personnel entering NIHD facilities.

To set forth hospital policy governing the conditions and terms allowed for service provided by outside governmental agents to patients at Northern Inyo Healthcare District (NIHD) and for the identification of regulatory agency personnel.

DEFINITIONS:

Governmental Representative

An individual acting on behalf of a federal, state, county, or local governmental agency.

Examples include, but are not limited to:

- California Department of Public Health (CDPH)
- Centers for Medicare & Medicaid Services (CMS)
- Office for Civil Rights (OCR)
- Inyo County Health and Human Services
- Adult Protective Services (APS)
- Child Protective Services (CPS)
- Law enforcement agencies
- Public health investigators

Regulatory Surveyor

An individual conducting accreditation, certification, licensure, or compliance activities on behalf of a regulatory or accrediting body, including but not limited to:

- The Joint Commission (TJC)
- CDPH
- CMS
- OCR

POLICY:

NIHD will cooperate with legitimate governmental agencies, regulatory surveyors, accrediting organizations, and authorized investigators consistent with applicable federal and California law, accreditation requirements, patient rights protections, and organizational security requirements.

1. All governmental or regulatory representatives shall report to the Administration, the Nursing Supervisor, or designated leadership upon arrival.

2. NIHD workforce members encountering governmental or regulatory representatives shall immediately notify leadership and shall not independently grant unrestricted access to patient care areas, records, or information systems.
3. Governmental and regulatory representatives must present official agency identification credentials prior to accessing restricted or patient care areas.
4. NIHD reserves the right to verify credentials directly with the issuing agency before permitting access to restricted areas.
5. Governmental and regulatory representatives shall be escorted while in patient care, restricted, or non-public areas unless otherwise authorized by Administration.
6. Access to Protected Health Information ("PHI") shall be limited to the minimum necessary consistent with applicable law and the representative's legal authority.
7. No governmental or regulatory representative shall be provided direct access to NIHD information systems, network resources, or electronic health record systems unless specifically authorized by Administration, Compliance, Health Information Management, and Information Technology Services (ITS).
8. Workforce members shall cooperate professionally with legitimate governmental investigations and regulatory surveys consistent with applicable law and NIHD policy.
9. All governmental and regulatory representatives shall comply with applicable infection prevention, safety, confidentiality, and security requirements while onsite.
10. Photography, video recording, or audio recording within NIHD facilities is prohibited unless specifically authorized by Administration, Compliance, or otherwise required by law.

~~Governmental agents (Agent) from governmental agencies, including but not limited to:~~

~~Inyo County Health and Human Services~~

~~CDPH Facility Evaluator~~

~~Agents may be summoned to provide services at NIHD only by nursing supervisors and law enforcement personnel.~~

~~An Agent will be allowed to perform services for a patient only after meeting with the nursing supervisor on duty.~~

~~The nursing supervisor will verify that the Agent is wearing an identification badge. If the agent is not wearing an identification badge, the agent's identity will be verified by contacting the agency's home office and validating the name/title/badge number. Inyo County Agent identification can be confirmed against the Inyo County personnel list available on the hospital Intranet.~~

~~Nursing Supervisor or designee will escort the Agent to the Patient's location.~~

~~Upon completion of the Agent's service evaluation of the patient, the Agent may be given a temporary workspace designated by NIHD Management. Such a workspace will be isolated from areas where Protected Health Information is accessible. No NIHD employee may give an Agent access to the NIHD information system or computer network.~~

~~If an Agent needs Internet access for their personal laptop, the Nursing Supervisor may assist the Agent by providing the "Guest Password" for the NIHD Internet access.~~

~~Only Agents whose credentials have been verified will be allowed to enter patient care areas. Agent credentials may be verified by contacting the agency's home office and confirming name/title/badge number.~~

PROCEDURE:

A. Initial Response

If any person identifies themselves as a governmental representative, investigator, surveyor, or regulatory official:

1. Politely request identification credentials.

2. Escort the individual to:
 - o Chief Executive Officer;
 - o Administrator-On-Call;
 - o Chief Nursing Officer;
 - o Compliance Officer;
 - o Chief Operations Officer;
 - o Chief Human Resources Officer; or
 - o Nursing Supervisor.
3. Staff shall not:
 - o leave representatives unattended in restricted areas.
 - o provide system passwords.
 - o permit unsupervised access to records.
 - o or disclose information outside the representative's authorized scope.

B. Verification of Credentials

Leadership or designee shall:

1. Review official agency identification, including:
 - o name.
 - o title.
 - o agency affiliation.
 - o Badge number or credential number.
2. Verify credentials when appropriate by:
 - o contacting the agency directly.
 - o reviewing official survey notifications.
 - o accessing accrediting organization verification systems.
 - o or using other approved validation methods.
3. Document verification activities when operationally appropriate.

C. Regulatory Surveys

For regulatory or accreditation surveys:

1. Administration or designee shall coordinate the organizational response.
2. NIHD may assign staff escorts or liaisons to accompany surveyors during onsite activities.
3. Requested records and information shall be coordinated through:
 - o Administration.
 - o Compliance.
 - o Health Information Management.
 - o Human Resources.
 - o or other designated departments.
4. Workforce members shall cooperate professionally and provide accurate information during surveys and investigations.

D. Patient Privacy and Information Security

1. Access to patient information shall occur only as permitted by law and consistent with HIPAA, CMIA, CMS Conditions of Participation, accreditation requirements, and other applicable regulations.
2. Governmental representatives shall not be permitted independent access to:
 - o unattended records.
 - o workstations.
 - o shared drives.
 - o network resources.
 - o or electronic systems without authorization.
3. Temporary workspace provided to external representatives shall minimize exposure to confidential information.

- o Preferred workspace for Governmental Representatives or Regulatory Surveyors who need office space is the Administrative Meeting Room (AMR).
- 4. Guest wireless internet access may be provided in accordance with NIHD ITS policies.

E. Infection Prevention and Safety Requirements

All external governmental and regulatory representatives accessing patient care areas shall comply with:

- infection prevention requirements,
- isolation precautions,
- PPE requirements,
- safety procedures,
- and emergency protocols.

F. Suspected Fraudulent Representation

If an individual refuses to provide identification, refuses verification, behaves suspiciously, or leadership suspects fraudulent representation:

1. Administration and Security shall be immediately notified.
2. NIHD may:
 - o deny access,
 - o request the individual leave the premises,
 - o contact the agency directly,
 - o or contact law enforcement when appropriate.
3. Any suspected impersonation involving a regulatory agency shall be reported through appropriate organizational and agency reporting mechanisms.

REFERENCES

1. Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160 and 164
2. California Confidentiality of Medical Information Act (CMIA)
3. CMS Conditions of Participation / Conditions for Coverage
4. The Joint Commission Accreditation Standards
5. EMTALA Requirements
6. Section 1557 of the Affordable Care Act

If any person or persons identifying themselves as Inyo County staff are encountered, immediately escort the person(s) to a nursing supervisor:

If any person or persons identifying themselves as regulatory surveyors (e.g., from The Joint Commission (TJC), California Department of Public Health (CDPH), or Office of Civil Rights (OCR)) are encountered, immediately escort the person(s) to one of the following (in order of preference):

1. Chief Executive Officer
2. Administrator-on-call
3. Chief Nursing Officer
4. Chief of Operations
5. Compliance Officer
6. Chief Human Resources Officer
7. Nursing Supervisor

Administrative personnel will:

1. Make a photocopy of the identification of the surveyor or write down relevant information for verification purposes. This includes name, title, and badge number.
2. CDPH—Call the agency to verify the legitimacy at **909-383-4777**
3. TJC—Validate that the survey is legitimate by accessing your Joint Commission extranet site.
 - a. Access the Joint Commission’s website at www.jointcommission.org
 - b. Click on “the Joint Commission Connect” logo
 - c. Enter a login and password

~~Your organization's extranet site contains the following information (posted by 7:30 a.m. on the morning of your survey):~~

- ~~• Notification of scheduled Joint Commission event authorizing the surveyor's presence for the unannounced survey~~
- ~~• Surveyor name(s), picture and biographical sketch~~
- ~~• Scheduled survey dates~~

~~4. Assign a hospital employee to accompany the surveyor(s) during their survey~~

~~In the event that the surveyor(s) refuse to allow their identification to be documented for verification or if the administration suspects that the surveyor is an imposter:~~

~~1. Call the local **Police—873-5866**~~

~~Go to the Joint Commission (TJC) website and fill out the Homeland Security Incident Report (even if the imposters claim to be from another agency)~~

CROSS REFERENCES POLICIES AND PROCEDURES:

Supersedes: v.4 Governmental Agent Services



NORTHERN INYO HEALTHCARE DISTRICT NON-CLINICAL POLICY

Title: Just Culture Policy		
Owner: Chief Executive Officer	Department: Administration	
Scope: District-wide		
Date Last Modified: 06/02/2026	Last Review Date: No Last Periodic Review Date Set	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE: To establish a Just Culture philosophy throughout Northern Inyo Healthcare District

POLICY: Northern Inyo Healthcare District (NIHD) believes in a “Just Culture” that encourages employee self-disclosure and continual delivery of high-quality services for patients, employees, and the community it serves. NIHD wants employees to feel safe speaking up about reporting adverse events, near misses, and the existence of hazardous conditions. We also recognize that employees must balance personal and organizational values with:

- The duty to avoid causing unjustified risk or harm
- The duty to produce an outcome
- The duty to follow a procedural rule

Northern Inyo Healthcare District believes in a consistent, fair, systematic approach to managing behaviors that balances a non-punitive learning environment with the equally important need to hold persons accountable for their actions.

SUPPORTIVE INFORMATION: All managers, directors, and leadership will proactively assure employees that NIHD’s culture promotes reporting of safety events and that such events will be handled consistently and fairly. As part of the normal investigative process for any safety event, the manager or director will conduct an investigation to determine the type of behavior that led to the safety event and to distinguish between blameworthy and blameless actions. The safety event will be assessed objectively and analyzed using a systematic approach based on five classifications of behaviors/actions:

1. Human Error
2. At-Risk
3. Reckless
4. Knowledge
5. Purpose

Exceptions to this approach will occur if an individual knowingly or willingly conceals a safety event or hinders a safety investigation, or causes a safety event or commits an unsafe act that results from:

1. An illegal act
2. A breach of confidentiality
3. A purposeful or reckless unsafe act
4. An act committed under the influence of alcohol, other substances, or that involves drug diversion
5. A persistent issue not resolved through performance improvement.

PROCEDURE: Safety Event: A safety event is any variance not consistent with the desired, normal, or usual operations of the organization. Safety events can involve patients, employees, visitors, or others. An injury does not have to occur.

Practice for all employees includes:

- Report a safety event as soon as the event has been discovered after taking appropriate immediate action.
- Formal reporting will be done using NIHD's event reporting system
- Safety event reporting is expected to occur the day the event occurred or was detected to assure accurate recall of the circumstances and facts surrounding the incident.
- If an employee believes he or she has been subjected to inappropriate punitive measures as a result of self-disclosure, the individual should report it to their department leadership, if appropriate, or to Human Resources.
- Expectations of staff:
- Avoid causing unjustified risk or harm (e.g., physical, financial, reputation, privacy, emotional). Look for the risks and hazards around you.
- Report errors and hazards (speak up)
- Help to design a safe system
- Manage safe choices:
 - Follow procedures
 - Make choices aligned with organizational values

Practice for Leaders includes: All leadership shall take proactive measures to assure their employees that NIHD's culture promotes full disclosure of safety events. Such events will be handled consistently with NIHD's philosophy of responding with a focus on process, prevention, and process improvement measures (versus punitive actions).

Upon formal notification of a safety event, operational leadership associated with the event will begin an investigation process to identify the type of behavior(s) that led to the safety event. These five behaviors/actions are:

1. Human Error- slip, lapse, or mistake; unintended error and a product of a current system design that often fails to consider the impact of the human factor
2. At-Risk- A choice; risk not recognized, risk of deviation deemed minimal or believed justified
3. Reckless- Intentional risk taking; knows the risk associated with the action but consciously disregards the risk
4. Knowledge- knowingly causing harm (sometimes justified)
5. Purpose- A purpose to cause harm (never justified)

In addition to these actions stemming from single events, an employee who has committed a series of human errors or at-risk behaviors whose cause does not originate within the work system will be subject to disciplinary action when non-punitive remedial action (e.g., education, coaching) is not effective in changing behavior.

Expectations for Leaders:

- Identifying and understanding the risk
- Investigating the source of errors and at-risk behaviors
- Turning risk events into learning events, as part of a learning health system culture:
 - Promoting the design of safe systems
 - Facilitating safe choices focused on managing behaviors:

Directors and Managers will follow a discipline process for reckless behaviors, including:

- Reckless disregard of the procedural risks associated with noncompliance.
- Reckless disregard toward harm to self or others; OR
- When remedial action (e.g., education, coaching) is not effective in changing behavior

Assistance: To further assist in the appropriate evaluation of these individual behaviors/actions, Human Resources and clinical quality and safety leaders are available to coach directors using the Just Culture

Algorithm. The Just Culture Algorithm is a tool intended to aid in determining the right course of action when an employee has made an error, drifted into an at-risk behavior, or has otherwise not met their obligations to the organization. Use of the algorithm is intended for those who have had training in the tool. In accordance with applicable significant event or risk management guidelines, managers, directors, senior leaders, and other healthcare team members may be notified depending on the severity of the concern or event.

DEFINITIONS:

AT RISK BEHAVIOR- behavior choice where risk is not recognized, or is mistakenly believed to be justified

COACHING- supportive discussion with the employee on the need to engage in safe behavioral choices

COUNSELING- a first step disciplinary action; putting the employee on notice that performance is unacceptable

DISCIPLINARY ACTION- actions beyond remedial, up to and including punitive action or termination

HUMAN ERROR-inadvertently doing other than what should have been done: a slip, lapse, mistake

IMPOSSIBILITY-condition outside of employee's control that prevents duty from being fulfilled

KNOWINGLY- having knowledge that harm is practically certain to occur

PERFORMANCE SHAPING FACTORS- attributes that impact the likelihood of human errors

PUNITIVE ACTION- punitive deterrent to cause an individual or group to refrain from undesired behavioral choices

PURPOSE- conscious objective to cause harm

RECKLESS BEHAVIOR- behavioral choice to consciously disregard a substantial and unjustified risk

REMEDIAL ACTION- actions taken to aid the employee, including education, training, and assignment to a task appropriate to knowledge and skill

SUBSTANTIAL AND UNJUSTIFIABLE RISK- a behavior where the risk of harm outweighs the social benefit attached to the behavior

REFERENCES

1. Frankel A., et al.: Improving patient safety across a large integrated health care delivery system. *Int J Qual Health Care* 15 (suppl. 1):i31-i40, Dec. 2003.
2. Institute of Medicine: *To Err is Human: Building a Safer Health System*. Washington, DC: National Academy Press, 2000.
3. Just culture training for healthcare managers. *The Just Culture Community*. 10 June. 2008 <http://www.justculture.org>.
4. Marx D.: *Patient Safety and the "Just Culture"*: A Primer for Health Care Executives. New York City: Columbia University, 2001.

Supersedes: Not Set



NORTHERN INYO HEALTHCARE DISTRICT NON-CLINICAL POLICY & PROCEDURE

Title: Language Access Services		
Owner: Compliance Officer	Department: Compliance	
Scope: District-wide		
Date Last Modified: 06/30/2026	Last Review Date: No Last Periodic Review Date Set	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

Northern Inyo Healthcare District (“NIHD” or “District”) is committed to providing meaningful access to healthcare services for patients and representatives with limited English proficiency (“LEP”), disabilities affecting communication, or other communication barriers.

This policy establishes NIHD’s requirements for:

- language access services,
- interpreter services,
- translation services,
- communication accommodations,
- bilingual workforce standards,
- and governance for handheld AI-assisted interpreter devices (“HHI”).

The purpose of this policy is to ensure:

- safe and effective communication,
- compliance with applicable federal and California laws,
- protection of patient rights,
- and reduction of clinical and regulatory risk.

~~To ensure meaningful access and effective communication for:~~

- ~~Individuals with Limited English Proficiency (LEP) and their companions, and~~
- ~~Individuals who are Deaf/Hard of Hearing, have speech disabilities, or other communication needs,~~

~~by providing free, timely, and accurate language assistance and auxiliary aids/services, consistent with federal and California requirements.~~

DEFINITIONS:

Approved Qualified Bilingual EmployeeBilingual

A workforce member who:

- has successfully completed District-approved language proficiency testing.

- has been approved by NIHD to communicate directly with patients in a language other than English within the scope of their role.
- and has completed any required education or competency validation.

Qualified Interpreter

An individual who:

- demonstrates proficiency in English and at least one additional language.
- accurately interprets specialized medical terminology.
- adheres to interpreter ethics and confidentiality requirements.
- and is qualified through training, testing, certification, or contracted interpreter services.

Qualified interpreters may include:

- over-the-phone interpreters.
- video remote interpreters.
- American Sign Language interpreters.
- or approved bilingual workforce members functioning within approved scope.

Handheld AI-Assisted Interpreter Device (HHI)

A District-approved electronic communication device or software utilizing artificial intelligence, machine translation, or automated speech translation technology to facilitate communication between individuals speaking different languages.

HHI devices are not considered qualified interpreters.

Limited English Proficient (LEP)

An individual whose primary language is not English and who has a limited ability to read, write, speak, or understand English.

—a term describing a person who is “proficient” in two languages.

There are different levels of proficiency, and being self-declared bilingual does not ensure the ability to interpret or provide services in

Limited English Proficient (LEP) or Non-English Speaking — ~~an individual that does not speak English well enough to take care of his/her health care needs. In most cases, these individuals do not speak English as their primary or preferred language, and have a limited ability to read, speak, write, or understand English.~~

Preferred Language

The language indicated by the patient as being the one in which he/she would like to communicate while receiving health care services. This should be documented in the EHR. ~~A patient’s preferred language may/may not be the same as his/her primary language.~~

Primary Language

The language a person has learned from birth. This also should be documented in the EHR.

Qualified Bilingual Employee — ~~a workforce member with assessed proficiency in a language other than English, with the ability (and approval) to directly provide services to LEP patients in their primary or preferred language.~~

Qualified Interpreter — ~~a person fluent in English and the needed second language (or sign language), able to competently interpret clinical terms (e.g., body parts, symptoms/injuries). Able to provide effective, accurate, and impartial interpretations in an ethical manner.~~

Sign(ed) Language — ~~all different forms of communication used by interpreters for the deaf, including American Sign Language (ASL) and other sign language variants. Sign languages for the deaf are unique languages with their own syntax and are not signed versions of English or other spoken languages.~~

~~**Sign Language Interpreter**—An individual, who mediates signed communication for the hearing impaired or deaf, holding a certification from an accredited institution to providing Signed Language interpreting.~~

Translation

The conversion of a written text into a written text in a second language.

Threshold Language

A language identified as the primary language, as indicated on the Medi-Cal Eligibility Data System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.

The only threshold language meeting this definition in NIHD’s service area, at the time this policy is reviewed is Spanish.

Vital Document

Documents containing information critical to:

- patient rights,
- informed decision-making,
- access to services,
- consent,
- formal grievances,
- legal rights,
- or patient safety.

~~—Vital Documents are those containing information for accessing services and/or benefits. Including, but not limited to:-~~

- ~~a) Informed Consent;~~
- ~~b) Advance Directive;~~
- ~~c) Intake forms with potential for important health consequences;~~
- ~~d) “Notices pertaining to the denial, reduction, modification or termination of services and benefits, and the right to file a grievance or appeal;”¹ and~~
~~Notices advising LEP persons of free language assistance, or applications to participate in a program or activity to receive benefits or services.²~~

Workforce Member

NIHD employees and any other person whose conduct, in the performance of work for NIHD, is under the direct control of NIHD, whether or not they are paid by NIHD. This includes Medical Staff members, including members of all Staff categories, temporary privileges holders, and allied health professionals; travelers, temporary, per-diem, full- and part-time employees, affiliates, associates, students, volunteers, and staff from third-party entities providing services to NIHD.

POLICY:

NIHD shall provide timely, appropriate, and effective communication assistance to patients and representatives experiencing language or communication barriers, including individuals who:

- have limited English proficiency,
- are non-English speaking,
- are deaf or hard of hearing.

¹ California Health and Safety Code § 1367.04(b)(1)(B)(i)-(vi)

² According to the Title VI Office of Civil Rights Guidance, the definition of Vital Documents “may depend upon the importance of the program, information, encounter, or service involved, and the consequences to the LEP person if the information in question is not provided accurately or in a timely manner.”

- have speech impairments,
- have visual impairments affecting communication,
- or otherwise require communication accommodations.

Language access services shall be provided:

- free of charge to the patient,
- without unreasonable delay,
- and in a manner that protects patient privacy, safety, dignity, and informed decision-making.

NIHD shall not discriminate on the basis of:

- national origin,
- race,
- color,
- disability,
- ancestry,
- or language proficiency.

~~Northern Inyo Healthcare District will:~~

- ~~1. Provide language assistance at no cost to patients/companions with LEP and to individuals needing auxiliary aids/services to communicate effectively.~~
- ~~2. Offer qualified interpreters (spoken/signed) and qualified translators when interpretation/translation is required.~~
- ~~3. Use video remote interpreting (VRI), over-the-phone interpreting (OPI), handheld interpreting devices, in-person interpreters (when available/appropriate), and qualified bilingual staff as described below.~~
- ~~4. Not require patients to provide their own interpreter, and will avoid using family/friends or minors except in limited, legally permissible situations.~~
- ~~5. Provide notice of the availability of language assistance and auxiliary aids/services as required (including posting/public-facing notices and providing information in commonly encountered languages).~~

PROCEDURE:

1) GENERAL PROCEDURAL INFORMATION

- NIHD-approved language access resources include:
 - Qualified bilingual employees approved by NIHD;
 - Contracted over-the-phone interpreter services;
 - Contracted video remote interpreter services;
 - Contracted American Sign Language (ASL) interpreter services;

- v) Contracted written translation services;
 - vi) District-approved communication aids and auxiliary services;
 - vii) District-approved handheld AI-assisted interpreter (HHI) devices for limited permitted use.
- b) Interpreter and communication assistance services shall be provided at no cost to the patient.
- c) The unavailability of a specific interpreter modality shall not unreasonably delay medically necessary care. Staff shall immediately utilize available approved interpreter resources.
- d) NIHD shall document:
 - i) preferred spoken language,
 - ii) primary language,
 - iii) preferred written language when applicable,
 - iv) communication accommodation needs,
 - v) and interpreter modality utilized, along with interpreter or HHI identification.
- e) NIHD shall comply with all federal and state laws, and the Joint Commission's Standards related to the collection of patients' race, ethnicity, primary language, and preferred language for communicating while receiving health care services at NIHD.
- f) Qualified interpreters or approved qualified bilingual employees, and NOT HHIs, shall be utilized for:
 - i) informed consent,
 - ii) diagnosis discussions,
 - iii) treatment discussions,
 - iv) medication counseling,
 - v) discharge instructions,
 - vi) patient rights,
 - vii) grievance processes,
 - viii) advance directives,
 - ix) financial consents,
 - x) behavioral health evaluations,
 - xi) legal documentation,
 - xii) interpretation of legal or financial documents,
 - xiii) behavioral health crisis communication,
 - xiv) and any medically significant communication.
- g) District-approved HHI devices may be used for:
 - i) comfort rounding,
 - ii) repeat medication administration following initial counseling,
 - iii) meal requests,
 - iv) room orientation,
 - v) environmental services communication,
 - vi) transport instructions,
 - vii) basic non-clinical communication,

- viii) simple exam positioning instructions,
 - ix) in-exam instructions or directions,
 - x) and other low-risk routine communication.
- h) Workforce members:
- i) shall understand the limitations of AI-assisted translation technology,
 - ii) shall not rely upon HHI devices for clinically significant communication,
 - iii) and shall immediately escalate to qualified interpreter services when medically significant communication occurs.
- i) NIHD may not use family members or friends as interpreters.**
- i) NIHD encourages patients not to use friends or family members as their interpreter, and does not allow the utilization of anyone under the age of 18 years of age as an interpreter
- j) NIHD recognizes patients' right to self-autonomy, and their right to refuse to use the qualified interpreter services provided by the District.
- i) If a patient requests use of a family member or friend:
 - (1) document the patient's refusal of District interpreter services using the Waiver of Interpreter Services Form,
 - (2) and document the patient's interpreter preference,
 - (3) connect to a qualified interpreter for the protection of the District, member of workforce, and patient.
 - ii) A patient can waive or refuse their right to a qualified interpreter however, **no member of the workforce has the right to waive the district's requirement for the qualified interpreter.**
 - iii) The patient must receive communication in a language that allows the patient to receive, and the District to provide, high-quality health care that a patient can understand and make appropriate medical decisions.
 - iv) NIHD requires a qualified interpreter when necessary to ensure safe and accurate communication. An HHI may be used for interpreting as described in the above section of this policy.
- k) NIHD shall maintain translated versions of required vital documents in threshold languages as required by law and operational necessity. At minimum:
- i) notices of language assistance availability,
 - ii) patient rights,
 - iii) grievance information,
 - iv) and other legally required documents
 - v) shall be translated consistent with applicable federal and California requirements.
 - vi) All requests for translation shall be submitted to the Compliance Department.
- l) When obtaining the patient's signature for any translated document, workforce members should use both forms, the one in English and its Spanish translation.
- i) The patient should sign the form in their preferred language.
 - ii) The witness should sign both, as they are witnessing the signature (and not the explanation or understanding of the document).
 - iii) Both forms should be in the EHR. Spanish, as that is the consent the patient can read and understand. The English copy because our medical records are in English.

- m) NIHD shall provide appropriate auxiliary aids and services to individuals with disabilities affecting communication, including:
 - i) ASL interpretation,
 - ii) video remote ASL interpretation,
 - iii) written communication,
 - iv) assistive communication devices,
 - v) or other reasonable accommodations.
- n) NIHD shall:
 - i) notify patients of available language access services,
 - ii) provide notices in required languages,
 - iii) and post appropriate signage informing patients how to access interpreter services.
- o) Appropriate workforce members shall receive education regarding:
 - i) access to interpreter services,
 - ii) documentation requirements,
 - iii) bilingual employee limitations,
 - iv) patient rights,
 - v) and HHI permitted/prohibited uses.
- p) Members of the workforce who would like to become qualified bilingual employees should reach out to their supervisor.
 - i) NIHD uses a third-party vendor to provide education and testing for bilingual workforce, coordinated through the Compliance and Human Resource departments
 - ii) All qualified bilingual staff have “Bilingual” printed on their identification badge

2) OPERATIONAL PROCEDURE

a) Identification of language need

- i) At the earliest practical point of contact, workforce members shall:
- ii) identify preferred spoken language,
- iii) identify communication barriers,
- iv) determine interpreter needs,
- v) document applicable information in the medical record.

b) Accessing interpreter services

- i) Telephone Interpretation
 - (1) Staff shall access District-approved telephone interpreter vendors according to departmental workflow.
- ii) Video Remote Interpretation (VRI)
 - (1) District-approved video interpretation devices shall be utilized when:
 - (a) visual communication is beneficial,
 - (b) ASL services are needed,
 - (c) or patient care circumstances warrant video interpretation.

c) Qualified Bilingual Employees

- i) Qualified bilingual employees may directly communicate with patients only within:
 - (1) their approved competency level,
 - (2) their approved role,

(3) and District authorization.

d) Documentation requirements

- i) Documentation should include, as applicable:
 - (1) patient preferred language,
 - (2) interpreter modality,
 - (3) interpreter vendor or ID number if available,
 - (4) bilingual employee use,
 - (5) patient refusal of interpreter services,
 - (6) use of family/friend interpreter,
 - (7) communication accommodation provided.

e) Escalation requirements

- i) Staff shall escalate immediately to qualified interpreter services when:
 - (1) communication becomes medically significant,
 - (2) patient understanding is unclear,
 - (3) consent or rights discussions occur,
 - (4) or HHI limitations become apparent.

f) Emergency situations

- i) In emergencies:
 - (1) staff may utilize the most immediately available communication method necessary to protect life or safety, while simultaneously attempting to obtain qualified interpreter services as soon as practicable.

g) Compliance

- i) Failure to comply with this policy may result in:
 - (1) corrective action,
 - (2) retraining,
 - (3) or disciplinary action consistent with District policy.

REFERENCES

1. Title VI of the Civil Rights Act of 1964
2. Americans with Disabilities Act (ADA)
3. Rehabilitation Act of 1973, Section 504
4. Affordable Care Act, Section 1557
5. CMS Conditions of Participation
6. CMS Critical Access Hospital Conditions of Participation
7. EMTALA
8. California Health & Safety Code §1259
9. California Health & Safety Code §1367.04
10. Joint Commission Patient-Centered Communication Standards

CROSS-REFERENCED POLICIES

1. Patient Rights and Responsibilities
2. Grievance Process

3. Medical Record Documentation
4. Conditions of Admission
5. Non-Discrimination Policy
6. Emergency Department Policies
7. Privacy and Confidentiality Policies

RECORD RETENTION

Documentation related to language access services use shall be maintained in the patient's medical record and retained/destroyed consistent with medical record retention policies.

Supersedes: v.3 Language Access Services Policy; Language Access Services Program



NORTHERN INYO HEALTHCARE DISTRICT NON-CLINICAL POLICY AND PROCEDURE

Title: Record Retention and Destruction		
Owner: Compliance Officer	Department: Compliance	
Scope: Districtwide		
Date Last Modified: 06/10/2026	Last Review Date: No Last Periodic Review Date Set	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

To establish a standardized framework for the retention, storage, protection, retrieval, and lawful destruction of records maintained by Northern Inyo Healthcare District (“NIHD” or “District”) in accordance with:

- Federal and California law;
- California Hospital Association (“CHA”) Record Retention recommendations;
- Centers for Medicare & Medicaid Services (“CMS”) Conditions of Participation;
- The Joint Commission standards;
- HIPAA/HITECH requirements;
- California healthcare district requirements; and
- Operational, legal, fiscal, clinical, and historical needs of the District.

This policy is intended to ensure records are retained for appropriate periods, protected from unauthorized access or destruction, and disposed of in a secure and legally compliant manner.

POLICY:

NIHD shall retain records for the minimum periods required by applicable federal and California law, regulatory guidance, accreditation standards, litigation hold requirements, payer obligations, contractual obligations, and operational needs.

Where multiple retention periods apply, NIHD shall retain records for the longest applicable period.

Records shall not be destroyed if they are:

- Subject to litigation hold;
- Relevant to an investigation, audit, subpoena, grievance, complaint, or government inquiry;
- Required for ongoing patient care;
- Subject to pending public records requests;
- Required under contract;
- Required for cost report or reimbursement purposes; or
- Otherwise required by law.

NIHD adopts the current CHA Record Retention Manual as the primary operational reference for retention schedules not specifically addressed in this policy.

DEFINITIONS:

Record

Any recorded information created, received, maintained, or stored by NIHD in any format, including:

- Paper;
- Electronic records;
- Emails;
- Text messages used for District business;
- Audio/video recordings;
- Scanned documents;
- Photographs;
- Microfilm;
- Databases; and
- Cloud-based records.

Legal Hold

A directive issued by the Compliance Officer, Legal Counsel, or Administration requiring suspension of normal destruction practices due to anticipated or actual litigation, investigation, audit, or governmental inquiry.

Destruction

Permanent disposal of records in a manner that renders the information unreadable, irretrievable, and incapable of reconstruction.

Electronically Stored Information (ESI)

“Electronically Stored Information (“ESI”)” includes emails, text messages, metadata, databases, voicemail, collaboration platform communications, cloud-hosted records, audit logs, electronic documents, and other electronically stored data maintained by or on behalf of the District.

RESPONSIBILITIES:

A. Custodian of Medical Records

The Manager of Health Information Management (“HIM”) is the designated Custodian of Medical Records and is responsible for:

- Retention and destruction of medical records;
- Coordination of medical record destruction;
- Ensuring HIPAA-compliant destruction methods;
- Maintaining destruction logs for medical records; and
- Ensuring preservation of records subject to hold requirements.

B. Custodian of Business Records

The Compliance Officer is the designated Custodian of Business Records and is responsible for:

- Oversight of non-medical record retention;
- Administration of retention schedules;
- Legal hold coordination;
- Destruction authorization;
- Oversight of business record destruction; and
- Maintenance of destruction documentation.

C. Department Directors and Managers

Department leaders are responsible for:

- Maintaining records within their operational areas;

- Ensuring records are stored securely;
- Following approved retention schedules;
- Identifying records subject to legal hold; and
- Coordinating destruction activities with the appropriate Custodian.

D. Information Technology Services

ITS shall support:

- Secure electronic storage;
- Backup management;
- Access controls;
- Electronic destruction methods; and
- Preservation of records subject to legal hold.

PROCEDURE:

A. RETENTION SCHEDULE:

NIHD adopts the current CHA Record Retention recommendations as the operational standard for records not specifically listed below.

The following retention periods represent minimum retention requirements.

Record Type	Minimum Retention Period
Adult patient medical records	Minimum 7 years from last encounter
Minor patient medical records	Minimum 1 year after the patient reaches age 18, but not less than 7 years.
Diagnostic imaging reports	Same as adult and minor medical record retention
Diagnostic images (if separately retained)	Same as adult and minor medical record retention
Emergency Department records	Minimum 7 years (or minor's records above)
Surgical records	Minimum 7 years (or minor's records above)
Behavioral health/SUD records	Per HIPAA, 42 CFR Part 2, California law, and CHA guidance
Birth and death records/logs	Permanent or per statutory requirements
Patient accounting/billing records	Minimum 15 years
Medicare/Medicaid cost reports	Minimum 15 years from final settlement, closure of appeal activity, or final reimbursement determination, whichever is later
All records supporting Medicare/Medicaid reimbursement, including worksheets, allocation methodologies, statistical data, wage index support, bad debt documentation, provider-based documentation, and audit support materials	Minimum 15 years
Financial records, general ledgers, trial balances, supporting accounting documentation, reimbursement support records, and related audit materials	Minimum 15 years
Government audit files, RAC/UPIC/ZPIC audit materials, reimbursement appeals, and settlement documentation	Minimum 15 years after final resolution
Chargemaster history and pricing	Minimum 15 years

support documentation	
Price transparency supporting documentation and machine-readable file history	Minimum 10 years
Charity care / financial assistance application and determination records	Minimum 10 years
HIPAA documentation	Minimum 6 years
Compliance program records	Minimum 10 years
Audit and investigation files	Minimum 10 years after closure
Incident/UOR reports	Minimum 10 years
Grievance and complaint files	Minimum 10 years
Board minutes and resolutions	Permanent
Board agendas and packets	Permanent
Contracts and agreements	Minimum 15 years after termination/expiration
Employment records	Minimum 10 years after separation unless longer required; records necessary to support defined benefit pension calculations shall be retained permanently or for the duration necessary to administer pension obligations.
Employee Health Records	Duration of employment plus 30 years
Payroll/timekeeping records	Payroll/timekeeping records – Minimum 15 years; records necessary to support defined benefit pension calculations shall be retained permanently or for the duration necessary to administer pension obligations.
Workers' compensation records	Minimum 10 years after closure
Occupational health records	Per OSHA and CHA guidance
Radiation Worker exposure records	Permanent or per regulatory requirements
Infection prevention records	Minimum 10 years
Credentialing and peer review records	Per Medical Staff Bylaws, California Evidence Code protections, and CHA guidance
Policy and procedure history	Retain superseded versions for a minimum of 10 years.
Email records	Retention periods for electronic communications shall be determined by the content and function of the communication, rather than the format or transmission method.
Routine transitory emails (scheduling, duplicates, non-substantive notices)	2 years
Operational/business emails	7 years
Executive leadership communications	7–10 years
Board-related communications	Board-related communications, agenda development materials, Board governance records, and communications relating to Board deliberations or actions – Minimum 10 years unless permanent retention is otherwise required.
Emails supporting contracts, claims, investigations, grievances, reimbursement, compliance, HR, or litigation	Retain according to the underlying record category, often 10–15 years
Communications supporting Medicare/Medicaid reimbursement or	Minimum 15 years

cost reports	
Emails related to pending claims/litigation/audits/CPRA request	Until the legal hold is released
Financial and tax records	Minimum 15 years
Insurance claim files	Minimum 10 years after closure
Construction/facility records	Permanent for major facilities records
Environmental/safety records	Per OSHA/CDPH/CHA guidance

Records associated with Medicare, Medicaid, governmental reimbursement, cost reporting, wage index reporting, reimbursement appeals, governmental audits, or supporting documentation for claims submission shall be retained for a minimum of fifteen (15) years due to extended federal audit exposure, reimbursement reopening periods, False Claims Act considerations, and reimbursement appeal timelines.

Where CHA recommendations or applicable law require longer retention, the longer period shall apply.

Where state and federal recommendations differ, the regulations requiring the longer retention shall apply.

B. Backup System Disclaimer

System backups and disaster recovery copies are maintained for business continuity purposes and are not intended to serve as official record retention repositories unless specifically designated.

C. Public Records Preservation

District records, including electronic communications, may constitute public records under the California Public Records Act and shall not be destroyed if:

- subject to a pending or anticipated CPRA request;
- reasonably related to foreseeable litigation;
- relevant to Board actions or deliberations;
- subject to audit or investigation; or
- Otherwise required to be preserved by law.

Destruction of records after receipt of a CPRA request, litigation preservation notice, subpoena, or governmental inquiry is prohibited unless authorized by Legal Counsel.

D. Legal Hold Procedure

Upon notice of litigation, audit, investigation, subpoena, government inquiry, or anticipated claim:

1. The Compliance Officer and/or Legal Counsel may issue a Legal Hold Notice.
2. Destruction of relevant records shall immediately cease.
3. Departments shall preserve all potentially relevant records.
4. ITS shall suspend automated deletion processes where applicable.
5. The legal hold remains in effect until released in writing.

Failure to comply with a legal hold may result in disciplinary action.

E. Record Storage and Security

Records shall be maintained in a manner that:

- Protects confidentiality;
- Prevents unauthorized access;
- Prevents alteration or destruction;
- Supports timely retrieval; and
- Complies with HIPAA, CMIA, and cybersecurity requirements.

Protected Health Information (“PHI”) and Confidential Information shall be secured in accordance with District privacy and security policies.

F. Record Destruction Procedure

1) General Requirements

Records eligible for destruction may only be destroyed:

- After expiration of the applicable retention period;
- With approval from the applicable Custodian;
- After verification, no legal hold exists; and
- Using secure destruction methods.

2) Approved Destruction Methods

Paper Records

Paper records containing confidential information shall be destroyed by:

- Cross-cut shredding;
- Pulverization; or
- Approved confidential destruction vendor services.

Electronic Records

Electronic records shall be destroyed through:

- Secure deletion;
- Media wiping;
- Degaussing;
- Physical destruction of media; or
- Other ITS-approved destruction methods.

Protected Health Information

PHI destruction shall comply with HIPAA guidance and CA regulations regarding rendering PHI unreadable and incapable of reconstruction.

G. Records of Destruction

NIHD shall maintain documentation of destroyed records.

The destruction log shall include:

- Description of records destroyed;
- Department;
- Inclusive dates of records;
- Retention authority;
- Date of destruction;
- Method of destruction;
- Vendor name (if applicable); and
- Name/title of approving individual.

Destruction logs shall be retained permanently.

Certificates of destruction provided by vendors shall be retained with the destruction log.

H. Suspension of Destruction

Routine destruction shall be suspended:

- During litigation holds;
- During active government investigations or audits;
- During pending claims or grievances where records may be relevant; or

- Upon direction of Legal Counsel, Compliance Officer, CEO, or HIM leadership.

Destruction shall also be suspended when records may relate to pending or anticipated governmental reimbursement review, Medicare or Medicaid audit activity, or alleged overpayment investigations.

I. Failure to Comply

Failure to comply with this policy may result in:

- Disciplinary action;
- Loss of records access privileges;
- Regulatory reporting obligations; and/or
- Legal liability to the District.

REFERENCES:

1. California Hospital Association Record Retention Manual
2. HIPAA Privacy Rule
3. HIPAA Security Rule
4. HITECH Act
5. California Confidentiality of Medical Information Act (CMIA)
6. California Evidence Code
7. California Labor Code
8. California Government Code
9. California Health & Safety Code
10. Centers for Medicare & Medicaid Services Conditions of Participation
11. The Joint Commission standards
12. OSHA regulations
13. 42 CFR Part 2

RECORD RETENTION AND DESTRUCTION:

As noted in this policy.

CROSS REFERENCE POLICIES AND PROCEDURES:

Supersedes: Not Set



NORTHERN INYO HEALTHCARE DISTRICT NON-CLINICAL POLICY AND PROCEDURE

Title: Sanctions for Breach of Patient Privacy Policies		
Owner: Compliance Officer		Department: Compliance
Scope: District-wide		
Date Last Modified: 06/30/2026	Last Review Date: No Last Periodic Review Date Set	Version: 9
Final Approval by: NIHD Board of Directors		Original Approval Date: 04/20/2011

PURPOSE



To comply with 45 CFR 164.530(e)(1), which requires, “a covered entity must have and apply appropriate sanctions against members of its workforce who fail to comply with the privacy policies and procedures of the covered entity”.

DEFINITIONS

Sanction - training with documentation in the employee record, disciplinary action, or termination.

Workforce - Employees, volunteers, trainees, medical staff members, clinically privileged providers, contracted personnel, and other persons whose conduct, in the performance of work for the District, is under the direct control of the District, whether or not they are paid by the District.

Incidental Disclosure – Federal law recognizes and permits incidental uses and disclosures. An incidental disclosure is defined as a disclosure that occurs as a by-product of another permissible or required use or disclosure, as long as the covered entity has applied reasonable safeguards and implemented the minimum necessary standard where applicable, with respect to the primary use or disclosure.

Inadvertent Violation - An unintentional privacy violation that occurs despite the workforce member following applicable District policies, procedures, and reasonable safeguards.

Intentional Violation – Any knowing, purposeful, reckless, or deliberate unauthorized access, use, disclosure, acquisition, viewing, sharing, transmission, alteration, destruction, or discussion of Protected Health Information (PHI) that violates District policy, applicable law, or a workforce member’s authorized job responsibilities, regardless of whether harm was intended.

Aggravating factors that may increase the severity of an intentional violation include, but are not limited to:

- conscious disregard of District policy or legal obligations,
- prior instruction or warning,
- repeated conduct,
- attempts to conceal the conduct,
- access involving multiple patient records,
- access involving family members, coworkers, celebrities, or community members,
- personal gain,
- retaliatory motive,

- malicious intent,
- or disclosure of records protected under 42 CFR Part 2.

Negligent Violation - An unauthorized access, use, or disclosure of Protected Health Information (PHI) caused by carelessness, failure to follow District policy or procedure, inattention to detail, or failure to apply reasonable safeguards, without intent to improperly access or disclose the information.

Protected Health Information (PHI) - any individually identifiable health information regarding a patient's medical or physical condition or treatment in any form created or collected as a consequence of the provision of health care, in any format including verbal communication.

Privacy Breach – Any unauthorized or impermissible access, acquisition, use, disclosure, review, discussion, transmission, alteration, destruction, or handling of Protected Health Information (PHI), confidential patient information, or records protected under applicable privacy laws, including 42 CFR Part 2.

A Privacy Breach includes conduct that violates District privacy policies, procedures, or applicable law, regardless of whether the incident results in harm to a patient, compromises patient care, or meets the legal threshold for notification to affected individuals, governmental agencies, or regulatory authorities.

Privacy Breaches may include reportable and non-reportable incidents and may result in investigation, corrective action, sanctions, retraining, disciplinary action, or other remedial measures as determined by the District.

Reportable Breach – A Privacy Breach that meets the notification, reporting, or disclosure requirements established under HIPAA, HITECH, CMIA, 42 CFR Part 2, California Health and Safety Code §1280.15, or other applicable federal or state law.

Unauthorized - Access, acquisition, use, disclosure, review, transmission, discussion, or handling of Protected Health Information (PHI) without a legitimate work-related need, patient authorization, legal authority, or other lawful permission under District policy or applicable law. This conduct is not permitted, regardless of intent.

Malicious – An intentional unauthorized access, use, or disclosure of Protected Health Information (PHI) undertaken for personal gain, retaliation, harassment, exploitation, reputational harm, criminal purpose, or with intent to harm a patient, workforce member, or the District.

42 CFR Part 2 Records – Records or information created, received, maintained, or transmitted by a federally assisted substance use disorder (SUD) treatment program or lawful holder that identify an individual as having or having had a substance use disorder, having sought or received SUD treatment, or having been referred for SUD treatment, as protected under 42 CFR Part 2.

POLICY:

1. Workforce members must guard against improper access, use, or disclosure of PHI.
2. A workforce member who inadvertently releases protected health information incorrectly is required to report the incident as soon as the incident is known to have occurred via an Unusual Occurrence Report (UOR), phone call to Compliance, or email to Compliance@nih.org.
3. Northern Inyo Healthcare District's (NIHD) sanctions are applied based upon the severity, nature, intent, scope, and circumstances of the privacy violation utilizing the District's Incident Severity Scale. All

workforce members who commit a privacy violation shall be treated consistently under this process regardless of rank or position.

4. Any intentional, unauthorized, or willful access, use, or disclosure of PHI, including access due to curiosity, personal concern, familial relationship, social interest, celebrity status, employment interest, or any other non-work-related purpose, constitutes an intentional privacy violation.
5. NIHD monitors access to electronic health records, information systems, and other systems containing Protected Health Information (PHI). Workforce members should have no expectation of privacy regarding access to District systems, records, or information maintained within District information systems to the extent permitted by law.
6. NIHD may report privacy violations to applicable licensing boards, governmental agencies, law enforcement, accreditation organizations, or regulatory entities as required or permitted by law.
7. Workforce members must maintain the confidentiality of substance use disorder (SUD) patient records protected under 42 CFR Part 2 in addition to HIPAA, CMIA, and other applicable privacy laws. Unauthorized access, use, disclosure, discussion, review, transmission, or handling of records protected under 42 CFR Part 2 may result in disciplinary action up to and including immediate termination, reporting to applicable licensing boards or governmental agencies, and other corrective action permitted by law.
8. NIHD shall investigate suspected privacy violations in a fair, timely, and consistent manner. Investigations may include audit log review, document review, witness interviews, system access review, and consultation with Compliance, Human Resources, Information Security, leadership, Legal Counsel, or other appropriate personnel. Disciplinary determinations shall be based upon the facts and circumstances of the incident, including intent, scope, patient impact, operational impact, prior history, applicable law, and collective bargaining agreement requirements.

Malicious—Operational Relationship Between the Terms

<u>Term</u>	<u>Focus</u>	<u>Intent Required?</u>	<u>Severity</u>
<u>Unauthorized</u>	<u>Was it permitted?</u>	<u>No</u>	<u>Variable</u>
<u>Negligent</u>	<u>Carelessness/failure to follow safeguards</u>	<u>No</u>	<u>Moderate</u>
<u>Intentional</u>	<u>Purposeful act</u>	<u>Yes</u>	<u>Significant</u>
<u>Malicious</u>	<u>Intent to harm/exploit/gain/harass</u>	<u>Yes</u>	<u>Highest</u>

willful or criminal act by employee, deliberate or willful violation of District policies, violation may be harmful, or done for personal gain.-

PROCEDURE:

1. Breach Incident Determination of Severity

- a. **Minor Breach** – A Minor Breach is an isolated, inadvertent privacy violation that occurs despite the workforce member following applicable District policies, procedures, and reasonable safeguards.

Examples include, but are not limited to:

- Accidentally sending an email containing PHI to the wrong recipient while following established procedures;
- Accidentally sending a fax containing PHI to the wrong destination after verifying the fax number and following established procedures;
- Other isolated errors that occur despite compliance with District policies and reasonable safeguards.

b. Moderate Breach – A Moderate Breach is a privacy violation resulting from negligence, failure to follow District policy, inattention to detail, or a pattern of minor breaches.

Examples include, but are not limited to:

- Failing to log off a computer workstation containing PHI;
- Accessing patient lists without a legitimate work-related reason;
- Failing to verify patient registration, guarantor, insurance, provider, or order information when required by District policy;
- Faxing PHI to an unverified fax number;
- Repeated minor privacy violations; or
- Other negligent conduct that results in unauthorized access, use, or disclosure of PHI.

c. Major/Severe Breach – A Major/Severe Breach is an intentional, reckless, malicious, or otherwise serious privacy violation, including a pattern of moderate breaches, a willful violation of law or District policy, unauthorized access to patient information, or conduct that creates significant legal, regulatory, reputational, or operational risk to the District.

Major/Severe Breaches generally warrant Level 3 or Level 4 corrective action and may result in immediate termination depending on the circumstances, severity, intent, scope of access, prior history, patient impact, legal exposure, operational impact, and applicable collective bargaining agreement provisions.

- Aggravating factors that may increase the severity of corrective action include:
- Repeated conduct;
- Prior instruction, counseling, or warnings;
- Attempts to conceal the conduct;
- Malicious intent;
- Personal gain;
- Retaliatory conduct;
- Broad scope of access or disclosure;
- Access involving multiple patient records; or
- Access, use, or disclosure involving records protected under 42 CFR Part 2.

Examples include, but are not limited to:

- "Snooping" or accessing patient records without a legitimate work-related need;
- Accessing the records of family members, friends, coworkers, celebrities, public figures, or community members without authorization;

- Accessing multiple patient records out of curiosity, concern, or personal interest;
- Accessing emergency department, inpatient, clinic, or other patient records without involvement in the patient's care or operational responsibilities;
- Destroying, altering, or attempting to alter patient information or District records;
- Attempting to gain unauthorized access to patient information or District information systems;
- Hacking, attacking, or compromising District information systems;
- Posting PHI on social media or otherwise intentionally disclosing PHI without authorization;
- Accessing, using, or disclosing records protected under 42 CFR Part 2, including medication-assisted treatment (MAT) records, substance use disorder treatment information, counseling records, referral information, or information identifying an individual as receiving or seeking substance use disorder treatment; or
- A pattern of repeated moderate privacy violations.

~~A. **Minor Breach**—an accidental breach, a singular instance or incident of an inadvertent breach~~

~~family or friend due to concern OR inappropriate access of multiple patient charts due to curiosity or concern OR inappropriate access of multiple patient charts for whom you are not involved in their care.~~

~~Examples include but are not limited to: intentional access of emergency patient charts without being involved in their care/covering in the unit, or without being informed the patient will be admitted OR destroying or altering data OR accessing or attempting to gain access to patient information which the workforce member does not need to access to perform their job OR attacking or hacking District information systems OR releasing patient data with the intent to harm an individual or the District OR posting PHI on social media OR a pattern of repeated moderate violations.~~

2. Whistleblower Protection

- Neither the District nor any workforce member of the District may intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual who reports any conduct that is unlawful or otherwise violates professional or clinical standards, including, but not limited to, the reporting of conduct that results in the breach of privacy of any patient of NIHD.

- Proven violation of this section will result in immediate loss of employment.

3. Disciplinary Action

~~4.—~~

- Disciplinary action, up to and including termination, based on recommended corrective actions in “Sanctions for Breach of Patient Privacy – Incident Severity Scale”, will be taken for any workforce member for a violation of privacy and security policies and procedures. NIHD prohibits the use of District systems, records, equipment, or resources for unlawful purposes or in a manner inconsistent with applicable privacy and confidentiality laws, including HIPAA, CMIA, Health and Safety Code §1280.15, Health and Safety Code §130200, and 42 CFR Part 2.

- Unauthorized access to, or disclosure of, substance use disorder treatment records protected under 42 CFR Part 2 may be considered a Major/Severe Breach regardless of whether the workforce member intended harm.

5. Standard Sanctions – Levels

- a. Level 1: Re-training and/or coaching memo.
- b. Level 2: Documented verbal counseling or written warning, as determined by leadership in conjunction with Human Resources, placed into the workforce member's Human Resources (HR) File.
- c. Level 3: Final written warning, probation, or suspension, including notification that further violation of the privacy of PHI will result in termination, as determined by leadership in conjunction with HR. Documentation will be placed into the workforce member's HR file.
- d. Level 4: Termination.

6. Modification of Sanction Levels

- a. Action level may be modified by the consensus of the Privacy Officer, Chief Human Resources Officer, and the employee's manager by considering the following:
 - i. Previous history or corrective action (level of action may increase based on repeat offenses)
 - ii. Whether or not the individual caused an inadvertent violation based upon a situation or operation that the individual did not know caused the breach.
- b. Nothing in this policy alters applicable due process rights, collective bargaining agreement provisions, management rights, or other rights and obligations established under applicable law or District policy.

7. Standard Sanctions—Levels

a. ~~Level 1: Re-training and/or coaching memo.~~

~~8. Level 2: Documented verbal counseling or written warning, as determined by leadership in conjunction with Human Resources, placed into workforce member's Human Resources (HR) File.~~

~~9. Level 3: Written warning, probation, or suspension, including notification that further violation of the privacy of PHI will result in termination, as determined by leadership in conjunction with HR. Documentation will be placed in workforce member's HR file.~~

~~A. Level 4: Termination.~~

10. Modification of Sanction Levels

~~A. Action level may be modified by the consensus of the Privacy Officer, Chief Human Resources Officer, and the employee's manager by considering the following:~~

~~1. Previous history or corrective action (level of action may increase based on repeat offenses)~~

~~2. Whether or not the individual caused an inadvertent violation based upon a situation or operation that the individual did not know caused the breach.~~

Sanctions for Breach of Patient Privacy – Incident Severity Scale Tool

The sanction levels identified below are guidelines and not mandatory progressive discipline steps. NIHD reserves the right to determine the appropriate corrective action based upon the severity, intent, circumstances, patient impact, operational impact, legal exposure, prior history, and applicable law. Guidelines with recommended corrective actions, once an incident and an individual are identified.

		Action Level		
Level	Intention of the Individual Responsible for the privacy breach	Minor	Moderate	Major/Severe
A	Inadvertent examples including, but not limited to: - A mistake made while following District policy, OR - An error made due to a mistake by a patient	1	<u>2</u> 1	<u>2</u> 3
B	Negligent/Unintentional, examples including, but not limited to: - Carelessness or negligence, OR - Misdirected fax while not following District policy	2	3	3-4
C	Intentional examples including, but not limited to: - Due to curiosity or concern, OR - Access to patient charts without a work-related reason	<u>3</u> 2	<u>3</u> 3-4	<u>3</u> -4
D	Intentional examples including, but not limited to: - Willful or reckless disregard of policies, procedures, or law, OR - Malicious intent, including accessing or using information in a domestic dispute, OR - Personal financial gain	4	4	4

REFERENCES:

1. Health Insurance Portability and Accountability Act (HIPAA) of 1996 as amended
2. Health Information Technology for Economic and Clinical Health (HITECH) Act as implemented through the revised HIPAA Omnibus Rule published on January 17, 2013, see 78 Fed. Reg. 5565 (Jan. 25, 2013) amending C.F.R. Parts 160 and 164
3. California Confidentiality of Medical Information Act (CMIA)
4. 45 CFR 164.530(e)(1)
5. [California Health and Safety Code § 1280.15](#)
6. [California Health and Safety Code Sec. 2-1280.15](#)
7. ~~Civil Code 56.36~~
8. California Health and Safety Code 130200
9. [42 CFR Part 2 – Confidentiality of Substance Use Disorder Patient Records](#)
10. [42 U.S.C. § 290dd-2](#)

RECORD RETENTION AND DESTRUCTION:

Records related to documentation placed in the workforce member's HR file are maintained for the length of employment, plus six (6) years.

Unusual Occurrence Reports are maintained for ten (10) years.

CROSS-REFERENCED POLICIES AND PROCEDURES:

1. [Sanctions for Breach of Patient Privacy Policies](#)
2. ~~Privacy Screen Policy~~
3. Password Policy
4. [Minimum Necessary Access, Use, and Disclosure of PHI](#)
5. [Using and Disclosing PHI for Treatment, Payment, and Operations](#)
6. [Sanctions for Breach of Patient Privacy Policies](#)
7. ~~Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information~~

Supersedes: v6 Sanctions for Breach of Patient Privacy
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NORTHERN INYO HEALTHCARE DISTRICT CLINICAL PROCEDURE

Title: Service and Therapy Animals and Pets in District Buildings		
Owner: Manager, Employee Health & Infection Control	Department: Infection Prevention	
Scope: District-wide		
Date Last Modified: 01/20/2026	Last Review Date: No Last Periodic Review Date Set	Version: 5
Final Approval by: Medical Executive Committee	Original Approval Date: 08/2008	

PURPOSE:

To establish guidelines for the safe and effective integration of service animals, therapy animals, and therapy handlers into the NIHD District to enhance the well-being of patients, visitors, and staff.

~~Animals have an increasing presence in healthcare facilities. There are proven benefits for patients, visitors, and even staff, but there are also concerns.~~

~~This procedure delineates the safety guidelines that are to be followed, as defined by the Society for Healthcare Epidemiology of America (SHEA).~~

~~The goal of animal therapy and service animals is to keep patients, family, visitors, and staff all safe while still allowing the patient the comfort of a four-legged friend during a hospital stay.~~

DEFINITIONS:

Direct Threat: A significant risk to the health or safety of others that cannot be eliminated or mitigated by a modification of practices or procedures, or by the provision of auxiliary aids or services.

Emotional Support or Comfort Animal (ESA): ~~An animal that provides a therapeutic benefit through devotion, affection, and companionship but does not have training to perform specific tasks for the person's disability/diagnosis.~~ An animal that provides comfort or emotional support but is not specifically trained to perform tasks for a person with a disability. ESAs are not covered under the ADA and are only permitted as a reasonable accommodation in limited circumstances.

Individual with a Disability: A person who has a physical or mental impairment that substantially limits one or more major life activities, including, but not limited to, walking, talking, seeing, breathing, or hearing.

Handler: The person responsible for controlling and providing care for an animal.

Miniature Horse under ADA: Generally, they range in height from 24 inches to 34 inches measured to the shoulders and generally weigh 70 to 100 lbs.

Pet: An animal that is owned and cared for by an individual/patient that is not a Service Animal, Therapy Pet, or Emotional Support or Comfort Animal.

Pet Therapy: ~~The use of specifically trained/approved animals for interactions with patients with the intention of providing general therapeutic benefit.~~

Service Animal: An animal that is individually trained to do work or perform tasks for the benefit of an Individual with a Disability, including but not limited to:

1. A hearing animal
2. A guide animal
3. An assistance animal
4. A seizure alert animal
5. A mobility animal
6. A psychiatric service animal
7. An autism service animal

PROCEDURE:

I. Role of Animals by type

A. Service animals: The service animal is one that provides a specific service to the patient or visitor, most typically that is a guide dog for the blind.

1. NIHD allows service animals of patients and visitors into the facility to be compliant with the Federal Americans with Disabilities Act (ADA).
2. Only dogs and miniature horses are recognized as Service Animals under federal law.
3. Staff may ask the patient to describe the tasks that the animal performs, but it is against the law to require patients to produce “certification” papers proving the need for the animal’s assistance.
4. The hospital’s infection prevention team and nursing supervisor should be notified of the animal’s presence to ensure that the procedures are followed.

B. Personal pet visitation: Are visits requested by a patient, visitor, and/or family of the patient to allow a personal pet?

1. Admission of any pet is at the discretion of the nursing supervisor or department manager/leader.
2. In general, personal pets should not be allowed in hospitals, simply because it is harder to determine whether they have been cleaned, socialized, trained, or if they have the required vaccinations.
3. Exceptions to this rule can and should be made in cases where the benefit of having a patient’s pet visit outweighs the risks- though visits should still be restricted to dogs. No reptiles or birds will be allowed. Other mammals may be considered for approval in extenuating circumstances and under control.

Note: Cat visits are not allowed:

- Cats typically cannot be trained as well as dogs can.
- They pose a bigger infection risk: Cats are more likely to bite and scratch humans than trained dogs are, and cat injuries tend to spread more bacteria.
- People are *generally* more likely to be allergic to cats than dogs.

C. Animal-assisted activities (i.e., the pet therapy and volunteer program)

1. Dogs from established and recognized pet therapy training and certification organizations may be permitted to visit the NIHD campus, provided they meet all certification requirements and district standards. For example, the Alliance of Therapy Dogs is a certified volunteer organization that trains and certifies therapy dogs and handlers, either individually or in groups. A local group, Hounds with Heart, has recently formed under this program. Properly certified therapy dogs may visit only pre-approved departments. Therapy dogs are not permitted in operating rooms, ICUs, the nursery, food preparation areas, or any patient rooms under transmission-based precautions.
2. “Paws 4 Healing” is the local chapter, working in both Inyo and Mono counties, and is part of the nationally recognized **Pet Partners** organization.

3. ~~Dogs from other established pet therapy training organizations may also be allowed if they present their credentials prior to the visit.~~
4. The handler who has been approved to visit with the dog, ~~almost always~~ usually the dog's owner, has completed and passed the Pet ~~Partner course~~ Partner course. Handlers must also complete the hospital volunteer orientation and background check. The approved handler is responsible for the dog's behavior and control at all times during the visit. The handlers must:
 - Must reach out to the House Supervisor, department leadership, or Infection Prevention before visiting any departments.
 - Maintain their dog on a leash no longer than 4-6 feet.
 - Must ask permission before entering a patient's room and before the dog interacts with anyone.
 - The handler, patients, and staff before and after all interactions must practice hand hygiene.
 - Handlers must follow NIHD infection prevention practices
 - Handlers must strictly adhere to patient privacy and confidentiality guidelines (HIPAA).
5. The dog has also passed an in-depth course with an approved ~~evaluator; covering~~ evaluator covering all areas from:
 - **aAppearance, and Grooming:** Dogs must be clean, well-groomed, and free of parasites.
 - **Temperament:** Dogs must exhibit a stable, predictable, and gentle temperament suitable for a healthcare setting.
 - **Environmental Response:** The dog must demonstrate appropriate responses to unusual equipment, loud noises, sudden movements, and various flooring surfaces found in healthcare facility settings.
 - **Obedience Commands:** The dog must reliably respond to all essential obedience commands (e.g., sit, stay, down, leave it, come).
6. Veterinary Health Review: A licensed veterinarian must complete and sign a health examination form within the last 12 months, verifying the dog is in excellent health and fit to visit the hospital. This must be completed every 12 months.
7. Vaccinations: All therapy dogs must have current vaccinations, including a valid certificate of vaccination against rabies, which must be on file at all times. The House Supervisor will also have a copy of the handler and therapy dog information.
 8. ~~temperament, response to the unusual equipment and noises that may be experienced in a healthcare facility, training to commands known to be essential, and a review of the health examination required by a licensed veterinarian. All therapy dogs have been vaccinated against rabies.~~

~~H.~~ Service Animals

A. Identification

1. When it is not obvious what service an animal provides, only limited inquiries are allowed under the law. Workforce may only ask the following two questions:
 - a. Is this animal a Service Animal required because of a disability?
 - b. What work or task has the animal been trained to perform?
2. Workforce should not:
 - a. Ask about the person's disability. If a person asserts that an animal is required because of a disability, their response should be taken at face value.
 - b. Ask the Handler to demonstrate the Service Animal's work or task.
 - c. Ask for registration or certification documents. Service Animals are not required to be certified or registered.
 - d. Ask for ID cards.

- e. Ask for a letter from a physician.
- f. Charge additional fees because of the Service Animal.
- g. Refuse admittance, isolate, segregate, or treat the Individual with a Disability less favorably than other patients or visitors.
- h. Require that a Service Animal wear a harness, special patch, or vest.
- i. Interact with or distract the animal.

B. Access and Exclusion

1. A Service Animal shall be permitted in any area of the facility that is unrestricted to inpatients, outpatients, or visitors, provided that the Service Animal does not pose a Direct Threat and the presence of the Service Animal would not require a fundamental alteration in the facility's policies, practices, or procedures.
2. Consistent with Centers for Disease Control guidance, it is generally appropriate to exclude a Service Animal from limited-access areas that employ general infection control measures, such as:
 - a. Operating/procedure rooms;
 - b. Locations where immunosuppressed patients are being housed, including the Special Care Nursery, ICU, Surgery Unit, and Medical Unit; or
 - c. Locations where respiratory, enteric, or infectious precautions are in place.
 - d. See section VI-A for specific areas of exclusion.
3. If a determination is made to exclude a Service Animal from all or a portion of the NIHD facility, NIHD shall work with the Service Animal Handler to determine whether any reasonable modifications of policies, practices, or procedures are possible to accommodate the Service Animal.
4. In the event a Service Animal is excluded or removed from an NIHD facility, NIHD must offer the Individual with a Disability the opportunity to obtain goods or services without the Service Animal's presence.
5. A Service Animal Handler, which may be the Individual with a Disability, but does not have to be, must:
 - a. Control the Service Animal. Service Animals must be harnessed, leashed, or tethered, unless these devices interfere with the Service Animal's work or the individual's disability prevents using these devices. In that case, the Handler must maintain control of the Service Animal through voice, signal, or other effective controls.
 - b. Provide the Service Animal with food, water, and other necessary care (including toileting) or make such arrangements through family members, friends, or an accompanying person. NIHD Workforce is not responsible for providing care for Service Animals.
 - c. Clean up promptly after the Service Animal, or make arrangements for a family member, friend, or other person to clean up after the Service Animal. NIHD Workforce is not responsible for cleaning up after the Service Animal.
 - d. Ensure the Service Animal is vaccinated and licensed, to the extent required by state law and/or local ordinance.

C. Removal of the Service Animal

1. A Service Animal Handler will be asked to remove the Service Animal or make arrangements for the Service Animal to be removed from the facility in the event of the following:
 - a. The Service Animal is not responding to its Handler's attempts to control the Service Animal and has been determined by the House Supervisor (who has made an individualized assessment based on reasonable judgment) to be out of control.
 - b. The Service Animal is not housebroken or is incontinent.
 - c. The Service Animal otherwise poses a Direct Threat to the health and safety of others.

2. Carefully document the circumstances of the refusal/removal and contact the House Supervisor in the event a Service Animal is excluded. A single incident of refusal/removal does not necessarily mean that the Service Animal can be excluded indefinitely. The House Supervisor will assist in establishing future communications with the Handler.

III. Emotional Support/Comfort Animals and Pets

- A. Emotional Support or Comfort Animals are not considered to be Service Animals under the Americans with Disabilities Act or under California law. NIHD is not required by law to allow them access to District facilities. For purposes of this policy, NIHD shall treat Emotional Support/Comfort Animals in the same manner as Pets.
- B. Generally, Emotional Support/Comfort Animals or Pets are discouraged. Exceptions may be made. Exceptions may include the following:
 1. A patient experiencing a long-term stay.
 2. The patient is nearing the end of life.
- C. The decision to allow access in one of these scenarios and the duration of the access will be determined on a case-by-case basis by the House Supervisor and/or Infection Control with physician consultation when deemed necessary.
- D. The Emotional Support/Comfort Animal or Pet must be healthy, housebroken, and have a personality and obedience level appropriate for the health care setting.
- E. If permitted access to the facilities, the Handler of the Therapy or Emotional Support/Comfort Animal or Pet must:
 - Check in at the front desk upon arrival.
 - The House Supervisor will be notified and check Pet Therapy dog and handler information is current.
 - Once checked in, the Therapy animal-Emotional, Emotional Support/Comfort Animal, or Pet must go directly to the patient room or other designated visitation area. The door should remain closed for the duration of the visit.
 - Maintain control of the Emotional Support/Comfort Animal or Pet. The Emotional Support/Comfort Animal or Pet must be leashed or crated when entering and exiting the facilities.
 - The Handler will refrain from allowing any visitors or other patients to touch the Emotional Support or Comfort Animal or Pet.
 - Address the needs of the Emotional Support/Comfort Animal or Pet, including feeding, watering, and toileting. If unable to do so, the Handler may be asked to remove the Emotional Support/Comfort Animal or Pet from the premises.
 - NIHD House Supervisor may request that any Therapy or Emotional Support/Comfort Animal or Pet be removed or not returned to the facility for any reason.
 - Maintain their dog on a non-retractable leash no longer than 4 to 6 feet.

IV. Unanticipated Animals

- A. In the event that a patient arrives at the District facilities with an animal, the patient or family member will be asked to remove the animal from the facilities (if they are not a service animal with a care provider). If the patient and/or family member cannot remove the animal due to their health or need for care, NIHD will inform the patient or family member that the hospital and staff cannot be responsible for the animal and that the patient must contact someone to come retrieve the animal within thirty (30) minutes.
- B. If the animal is not removed by the patient and/or family member, the House Supervisor will contact Animal Control as necessary to assist in securing the animal.
- C. If the patient is unable to identify anyone to retrieve the animal or if no one arrives within the allotted thirty (30) minutes, the animal will be taken by animal control to the animal shelter. The patient and/or the patient's representative will be informed of the animal's location.

V. Pet Therapy Program

- a. The goal of the Program is to provide a soothing, familiar emotional experience that can have a positive impact on humans and their health status. To provide patients with an opportunity to interact with animals; to reduce the impact of the medical environment; to improve tactile stimulation; and to maintain or improve social skills. To provide a home-like environment. To provide an activity that does not focus on the illness. To provide a warm, loving animal to assist in the motivation of the patient in working towards treatment goals.
- b. All therapy dogs must be certified through ~~“Pet Partners” or “Therapy Dogs International, Inc.”~~
 - Pet Partners
 - Alliance of Therapy Dogs (ATD)
 - Therapy Dogs International; (TDI)
 - American Kennel Club (AKC) Therapy Dog Program
- c. Program visits must be provided in a safe manner and be consistent with Infection Control policies and practices. Only domestic companion dogs will be allowed to serve in this program; cats or other animals are not included.
 1. Specifically, before any visits take place, they must be approved by both the patient and the nursing staff. The staff will not relate what illness it is that patient may have to the team, just that the visit may or may not take place.
 2. Paws 4 Healing animals are required, through the certification process, to be clean for visits with short nails, clean hair, and clean ears. They are trained not to lick, scratch, or jump up. The dog must be parasite-free and have current inoculations. A dog must be over one (1) year of age to be in the program.
 3. Inappropriate behaviors from the dog will eliminate them from the Pet Therapy program.
 4. “Accidents” should be cleaned up by the handler, wearing gloves and using paper towels and a red plastic bag to contain urine and feces. Final cleaning with disinfectant shall be performed.
- d. The handler shall be a volunteer of NIHD. They are required to complete competency training and animal control skills and must be cleared by NIHD Employee Health for communicable disease protection. He/She is expected:
 1. To use proper precautionary measures to protect patients and personnel from infections that could arise from pet therapy visits.
 2. To promptly report incidents of positive disease exposure to the Clinical Manager or House Supervisor.
 3. To coordinate Program visits in accordance with approved District protocols.
 4. To monitor visits to ensure proper precautionary measures are taken.
 5. To report to the nurse caring for the patient, the effects of the pet therapy visit.
- e. Handling the Therapy Dog during the patient visit
 1. If the Therapy Dog is to lie on the bed or furniture, a clean sheet or blanket will be placed on the bed for the Therapy Dog to lie on. The hospital will provide linen when required. Protective linens are changed between patients. Roll sheets into the middle away from the patient. Place the dirty sheet in the linen hamper.
 2. The handler will keep a hand on the dog or hold the lead at all times.
 3. The handler is to prevent the dog from licking patients and Health Care personnel.
 4. Hand washing/hand sanitizer use will be performed by the patient before and after the pet visit. Assist the patient as needed.
 5. If the patient has any invasive devices such as a Foley catheter, IV, ventilation equipment, chest tubes, drains, or any other medical device, the Handler will approach the patient on the opposite side of the invasive devices in a manner to prevent the Therapy Dog from having direct contact with these devices.

VI. Exclusions:

A. Animals are not permitted in the following areas:

1. Food preparation areas
2. Labor and delivery areas
3. Medication storage/preparation areas
4. Perioperative Service areas (Surgery, Pre-op, PACU, and Sterile Processing)
5. Clean supply areas
6. Wound Care

B. Patients not eligible for Animal visitation:

(NIHD inpatients are in private rooms; therefore, animals may visit in other rooms on the same unit without harm to the ineligible patient.)

1. Patients with a history of allergy to dogs
2. Patients with a neutrophil count < 500.
3. Patients who have had a splenectomy
4. Patients being treated for an open wound
5. Patients in isolation
6. Patients who are afraid of dogs

REFERENCES:

1. ~~APIC Textbook of Infection Control and Epidemiology, 4th Ed, 2014~~
2. ~~Alliance of Therapy Dogs. (2023). About Alliance of Therapy Dogs. Retrieved from <https://www.therapydogs.com/alliance-therapy-dogs/>~~
3. ~~Scientific American: (2025) New hospital Guidelines Say No Cats Allowed, March 3, 2015 by Rachael Rettner and Live Science. Retrieved from <https://www.scientificamerican.com/article/new-hospital-guidelines-say-no-cats-allowed/>~~
4. ~~SHEA- Infection Control Today. Abstract March 2, 2015: Infection Control Experts Outline Guidance for Animal Visitations in Hospitals. Retrieved from <https://www.infectioncontrolday.com/view/infection-control-experts-outline-guidance-animal-visitations-hospitals>~~
5. ~~Americans with Disabilities Act. (2020). ADA Requirements Service Animals. Retrieved from <https://www.ada.gov/resources/service-animals-2010-requirements/>~~
6. ~~Americans with Disabilities Act, U.S. Department of Justice; Civil Rights Division. ADA Information Line (800) 514-0301 (voice) or (800) 514-0383 (TTY).~~
7. ~~American With Disabilities Act National Network. (2025). Service Animals and Emotional Support Animals: Where are they allowed and under what conditions? Retrieved from <https://adata.org/guide/service-animals-and-emotional-support-animals#:~:text=Titles%20II%20and%20III%20of,customer%2C%20or%20clients%20are%20allowed.>~~
8. ~~U.S. Department of Health and Human Services—Assistant Secretary for Preparedness and Response, Administration for Strategic Preparedness and Response (ASPR). Site accessed 11/28/2025: “Understanding How to Accommodate Service Animals in Health Care Facilities”. Retrieved from https://aspr.hhs.gov/at-risk/Pages/service_animals.aspx#:~:text=Service%20animals%20are%20to%20accompany,the%20nature%20of%20a%20facility%27s~~

RECORD RETENTION AND DESTRUCTION:

Documentation of Animal visits is included in the patient's medical record, which is maintained by the NIHD Medical Records Department.

Volunteer (handler) employee health records are managed by the NIHD Employee Health Specialist and must be maintained 6 for the duration of volunteer status, plus six (6) years.

CROSS-REFERENCED POLICIES AND PROCEDURES:

1. Lippincott Procedures; Pet therapy, pediatric (revised Nov. 19, 2021).
2. Lippincott Procedures: Pet Therapy, long-term care (reviewed May 21, 2021).
3. InQuiseek – Animals and Pet Policy

Supersedes: v.4 Therapy Animals and Pets in District Buildings
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NORTHERN INYO HEALTHCARE DISTRICT CLINICAL STANDARDIZED PROTOCOL

Title: Standardized Protocol – Minor Surgical Policy for the Physician Assistant			
Owner: Medical Staff Director		Department: Medical Staff	
Scope: Physician Assistants			
Date Last Modified: 04/04/2024		Last Review Date: 04/17/2024	
		Version: 4	
Final Approval by: NIHD Board of Directors		Original Approval Date: 02/20/2019	

PURPOSE:

1. This standardized protocol is designed to establish guidelines that will allow the Physician Assistant (PA) to perform minor surgical procedures incidental to the provision of routine primary care to ambulatory patients of Northern Inyo Healthcare District and affiliated locations.

POLICY:

1. This standardized protocol and those authorized to work through this standardized protocol will meet all guidelines as outlined in the *General Policy for the Physician Assistant*.
2. Circumstances:
 - a. Patient population: pediatric and adult patients
 - b. Setting: Northern Inyo Healthcare District (NIHD) and affiliated locations.
 - c. Supervision: Physician consultation is available at all times, either on-site, by phone, or by electronic means.

PROTOCOL:

1. Conditions: after appropriate training and experience (which includes a minimum of 5 proctored procedures each by a practitioner with unrestricted privileges in that procedure), minor procedures that can be performed by the PA without direct physician supervision include:
 - a. Pessary placement
 - b. Electrocautery of external, non-malignant, e.g. warts
 - c. Epidermal cyst removal
 - d. Incision and drainage of abscess (excluding peri-rectal abscesses)
 - e. Suture laceration without nerve or tendon involvement
 - f. Mole removal
 - g. Punch or shave biopsy
 - h. Toe nail removal
 - i. Cryotherapy
 - j. IUD insertion and removal
 - k. Excision of simple lesions
 - l. Simple foreign body removal

- m. Endometrial biopsy
 - n. Arthrocentesis/Steroid joint injection
 - o. Excision of hemorrhoid thrombus
 - p. Nexplanon insertion/removal
 - q. Circumcision of newborn
 - r. Vasectomy
2. Data Base:
- a. Subjective:
 - i. Obtain pertinent history including involved organ system, injury, trauma, dermatology problems, etc.
 - ii. Obtain information regarding review of system, risk taking behaviors, prior surgery, allergies, and immunizations.
 - b. Objective:
 - i. Perform physical examination pertinent to assessment of the problem.
 - ii. Collect appropriate diagnostic/radiological studies.
3. Assessment:
- a. Formulate diagnosis consistent with the above data base.
 - b. Document
4. Plan:
- a. Develop therapeutic regimen
 - i. Perform appropriate procedure utilizing standard aseptic technique.
 - ii. Obtain additional diagnostic studies as indicated.
 - iii. Physician consultation/assistance in performing the procedure as per policy statement or above conditions.
 - iv. Patient education and self-care techniques.
 - v. Development of appropriate follow-up care plan.
 - vi. Update problem list.
 - b. Provide written discharge instructions to the patient.

REFERENCES:

1. UpToDate-evidence-based, Physician-authorized clinical decision support resource

ATTACHMENTS:

1. List of Authorized Physician Assistants and Supervising Physicians

Supersedes: v.3 Standardized Protocol – Minor Surgical Policy for the Physician Assistant



Medical Staff Office
(760) 873-2174 voice
(760) 873-2130 fax

NORTHERN INYO HOSPITAL
Northern Inyo Healthcare District
150 Pioneer Lane, Bishop, California 93514

TO: NIHD Board of Directors
FROM: Samantha Jeppsen, MD, Chief of Medical Staff
DATE: July 7, 2026
RE: Medical Executive Committee Report

The Medical Executive Committee met on this date. Following careful review and consideration, the Committee agreed to recommend the following to the NIHD Board of Directors:

- A. Medical Staff Initial Appointments 2026-2027 (*action item*)
 - 1. Holly Wilbur, NP (*women's health nurse practitioner*) – Advanced Practice Provider Staff
 - 2. David Sarver, MD (*diagnostic radiology*) - Telemedicine Staff (GTR)



DATE: July 2026
 TO: Board of Directors, Northern Inyo Healthcare District
 FROM: Samantha Jeppsen, MD, Chief of Staff
 RE: Medical Staff Officers

Medical Staff Officers 2026-2027

In accordance with the Medical Staff Bylaws, the Active Medical Staff has elected the following officers, chiefs, and committee chairs to serve during the July 1, 2026 through June 30, 2027 Medical Staff year. Board approval of these appointments is requested.

CHIEF OF STAFF	Samantha Jeppsen, M.D.
VICE CHIEF OF STAFF	Anne Wakamiya, M.D.
IMMEDIATE PAST CHIEF OF STAFF	Sierra Bourne, M.D.
MEMBER-AT-LARGE	David Lichtenfeld, M.D.
MEMBER-AT-LARGE	Chelsea Robinson, M.D.
CHIEF/CHAIR OF EMERGENCY SERVICES	Samantha Jeppsen, M.D.
CHIEF/CHAIR OF INPATIENT MEDICINE	James Tur, M.D.
CHIEF/CHAIR OF OUTPATIENT MEDICINE	Anne Wakamiya, M.D.
CHIEF/CHAIR OF RADIOLOGY	Bradley Clark, M.D.
CHIEF OF OBSTETRICS	Martha Kim, M.D.
CHIEF OF PEDIATRICS	Lindsey Ricci, M.D.
CHIEF OF SURGERY	Connor Wiles, M.D.
CHIEF OF ORTHOPEDICS	Brian Gilmer, M.D.
CHIEF OF ANESTHESIA	Theodore Rasoumoff, M.D.
CHAIR OF PERI-PEDS	Lindsey Ricci, M.D.
CHAIR OF STTA	Theodore Rasoumoff, M.D.



DATE: July 2026
TO: Board of Directors, Northern Inyo Healthcare District
FROM: Samantha Jeppsen, MD, Chief of Medical Office
RE: Medical Staff Bylaw Amendment

MEMORANDUM

Follow-Up to Questions Raised at the June 2026 Board Meeting

At its June 2026 meeting, the Board reviewed the proposed Medical Staff Bylaw amendments and requested additional time before taking action. During the meeting, questions were raised regarding the proposed committee structure and the due diligence completed before the amendments were presented to the Board. The Medical Executive Committee provided the following additional information. After reviewing this information, General Counsel advised that the legal questions raised during the Board's June discussion had been satisfactorily addressed.

Question: What review was completed before the proposed amendments were presented to the Board?

Response: Yes. The proposed amendments were reviewed by Medical Staff legal counsel and BETA Healthcare Group Risk Management. In addition, the Medical Staff Director conducted a review for compliance with California Title 22, the CMS Conditions of Participation, and Joint Commission standards. Together, these reviews concluded the proposed amendments remain consistent with applicable legal, regulatory, accreditation, and risk management requirements.

Question: Are the proposed committee changes operationally and regulatorily appropriate?

Response: Yes. The proposed committee structure was reviewed with the Pharmacy Director and Infection Prevention Nurse, who confirmed the proposed changes remain operationally and regulatorily appropriate.

Question: Will moving the Infection Prevention Committee and the Pharmacy and Therapeutics Committee affect peer review protections under California Evidence Code section 1157?

Response: The Medical Staff advised that neither the Pharmacy and Therapeutics Committee nor the Infection Prevention Committee conducts protected peer review activities. The Medical Staff is concurrently establishing a multidisciplinary Peer Review Committee to ensure confidential peer review activities occur within the appropriate protected forum.

Question: Is this committee structure consistent with practices used by other California hospitals?

Response: Yes. The Medical Staff advised that similar committee structures are currently utilized by Mammoth Hospital and Tahoe Forest Hospital District.

Amendments to Northern Inyo Healthcare District Medical Staff Bylaws (*action item*)

The Active Medical Staff has voted to approve the following amendments to the Medical Staff Bylaws and submits them to the District Board for approval. These amendments allow the Medical Staff to carry out its responsibilities in self-governance and in ensuring the quality of care provided by members of the Medical Staff.

	Amendment
	Moving Infection Control Committee from a Medical Staff Committee to Hospital Committee. Medical staff participation and representation on this committee will remain intact as per law.
	Moving Pharmacy and Therapeutics Committee from a Medical Staff Committee to Hospital Committee. Medical staff participation and representation on this committee will remain intact as per law.
	Extending Medical Executive Committee membership to Chief of Anesthesia, Chief of Orthopedics and Chief of Surgery.
	Creation of a multidisciplinary Peer Review Committee to promote quality patient care and bring a standardized framework for assessing practitioner competency and providing practitioner feedback.

The Medical Executive Committee has additionally approved the following technical and editorial amendments and submits them to the District Board for approval. Technical and editorial amendments provide clarity in areas where bylaws language is ambiguous.

	Technical/Editorial Amendment
	Clearly specify the required limits for professional liability insurance are \$1M/\$3M instead of referring to other documents for this information.
	Remove duplicative notifications to the Chief of Staff when applications are requested and received.
	Clarify that applicant disclosures of “filed” professional liability cases includes cases that are dismissed.
	Specify the Board must be informed of corrective actions at their <i>next</i> regularly scheduled meeting following notification to the practitioner.
	Clarify that the parties notified of a corrective action are the same parties notified of a hearing request.
	Simplified language to add clarity that an amendment must be approved by a majority of the voting Medical Staff, regardless of whether the vote took place by mail, in person, or electronically.



NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

Title: Northern Inyo Healthcare District Medical Staff Bylaws		
Owner: Medical Staff Director		Department: Medical Staff
Scope: Medical Staff Practitioners		
Date Last Modified: 07/09/2026	Last Review Date: 08/21/2024	Version: 4
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Northern Inyo Healthcare District

Medical Staff Bylaws

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ARTICLE I: PURPOSE AND TERMS

1.1 PURPOSE OF THE BYLAWS

- (a) These Bylaws are adopted in recognition of the mutual accountability, interdependence and responsibility of the Medical Staff and the Northern Inyo Healthcare District Board of Directors in protecting the quality of medical care provided at Northern Inyo Healthcare District and assuring the competency of the District's Medical Staff. These Bylaws provide a framework for the self-governance of the Medical Staff, which is a collegial and democratic body with extensive knowledge in medical care. These Bylaws assure an organization of the Medical Staff that permits the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes, and to account to the Board of Directors for the effective performance of Medical Staff responsibilities. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Directors, and relations with applicants to and members of the Medical Staff.
- (b) These Bylaws address the Medical Staff's responsibility to establish criteria and standards for Medical Staff membership and privileges, and to enforce those criteria and standards. They establish clinical criteria and standards for quality assurance, utilization review, and other Medical Staff activities including, but not limited to, periodic meetings of the Medical Staff, its committees and departments, and review and analysis of patient medical records. They describe the standards and procedures for selecting and removing Medical Staff Officers, and they address the respective rights and responsibilities of the Medical Staff.
- (c) The Medical Staff acknowledges that the Board of Directors, in exercising its responsibility to protect the quality of medical care provided by and the competency of the Medical Staff and to ensure the responsible governance of the hospital, possesses administrative oversight authority of the Medical Staff. In exercising its administrative authority, the Board of Directors acknowledges and commits to respecting the rights and functions of a self-governing Medical Staff, as established by statute and through the Medical Staff Bylaws. The Medical Staff commits to exercising its rights and responsibilities with diligence and good faith, and acknowledges that if it does not do so, the Board of Directors may act, as delineated in these Bylaws, to fulfill the specific responsibility that the Medical Staff has failed to perform.

1.2 NAME

The name of this organization is the Medical Staff of Northern Inyo Hospital, a 501(c)(6) recognized organization.

1.3 PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

The Medical Staff's purposes are:

- (a) To assure that all patients admitted or treated in any of the Northern Inyo Healthcare District services receive a uniform standard of quality patient care, treatment and efficiency consistent with generally accepted standards attainable within the District's means and circumstances.
- (b) To support professional education and community health education.
- (c) To initiate and maintain rules for the Medical Staff to carry out its responsibilities for the professional work performed in Northern Inyo Healthcare District.
- (d) To provide an avenue for the Medical Staff, Board of Directors, and administration to discuss issues of mutual concern.

- (e) To exercise its rights and responsibilities in a manner that does not jeopardize the District's license, Medicare and Medi-Cal provider status, accreditation, and other credentialed statuses.

The Medical Staff's responsibilities are:

- (a) To provide quality patient care.
- (b) To assure for the benefit of the public, and also to account to the Board of Directors for, the quality of patient care provided by all members authorized to practice in Northern Inyo Healthcare District through the following measures:
 - (1) Review and evaluation of the quality of patient care provided through valid and reliable patient care evaluation procedures;
 - (2) A credentials program, including mechanisms of appointment, reappointment and the matching of clinical privileges to be exercised or specified services to be performed with the verified credentials and current demonstrated performance of the applicant;
 - (3) Participating in a utilization review program to provide for the appropriate use of all medical services.
- (c) To establish and enforce professional standards related to the delivery of healthcare within Northern Inyo Healthcare District.
- (d) To initiate and pursue corrective action with respect to members where warranted.
- (e) To cooperate with other community health facilities and/or educational institutions or efforts that strive to improve the quality of patient care within Northern Inyo Healthcare District.
- (f) To establish and amend as needed Medical Staff Bylaws and policies.
- (g) To select and remove Medical Staff Officers.
- (h) To assess and utilize Medical Staff dues as appropriate for the purposes of the Medical Staff.

1.4 DEFINITIONS

ACTIVE STAFF means the category of Medical Staff members who regularly provide care at Northern Inyo Healthcare District and meet the qualifications and prerogatives as listed in these Bylaws.

AD HOC COMMITTEE means a committee created for a particular purpose for a finite amount of time, as necessary.

ADVERSE ACTION means an action which is reportable under Business and Professions Code 805.

ADMINISTRATOR or CHIEF EXECUTIVE OFFICER means the person appointed by the Board of Directors to serve in an administrative capacity in the overall management of the District.

ADVANCED PRACTICE PROVIDER or APP means an individual, other than a licensed physician, dentist, or podiatrist, who exercises independent judgement within the areas of his or her professional competence and the limits established by the Board of Directors, the Medical Staff, and the applicable State Practice Act, who is qualified to render direct or indirect medical care under the supervision or direction of a Medical Staff member (with the exception of certified registered nurse anesthetists, who are APPs that practice under an independent license as per current California regulations).

AUTHORIZED REPRESENTATIVE means the individual(s) designated by the District and approved by the Medical Executive Committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these Bylaws.

BOARD OF DIRECTORS means the governing body of Northern Inyo Healthcare District.

CHAIR means the individual practitioner elected to preside over a committee or meeting.

CHIEF EXECUTIVE OFFICER see ADMINISTRATOR.

CHIEF MEDICAL OFFICER means an active member of the Medical Staff appointed by the Administrator to provide administrative support for the Medical Staff, communicate the views of the hospital administration to the Medical Staff, and serve as a liaison between the Medical Staff and the administration. The Chief Medical Officer shall serve on Medical Staff committees without vote unless otherwise specified at the time of appointment.

CHIEF OF STAFF means the chief officer or president of the Medical Staff elected by members of the Medical Staff.

CONTRACT PRACTITIONER means a practitioner who is party to a clinical services agreement with the District.

CONSULTING STAFF means the category of Medical Staff members who treat and otherwise care for patients at Northern Inyo Healthcare District and meet the qualifications and prerogatives as listed in these Bylaws.

COURTESY STAFF means the category of Medical Staff members who do not utilize Northern Inyo Healthcare District as the principle location of their practice but are given privileges and meet the qualifications and prerogatives as listed in these Bylaws.

CURRENT COMPETENCE means a combination of observable and measurable knowledge, skills, abilities and personal attributes that constitute a practitioner's performance within the last twenty-four (24) months.

DATE OF RECEIPT means the date any notice, special notice, or other communication was delivered personally; or if such notice was sent by mail, it shall mean seventy-two (72) hours after the notice, special notice, or communication was deposited postage prepaid, in the United States mail.

DAYS means calendar days, unless otherwise specified.

DEPARTMENT or CLINICAL DEPARTMENT is a group of practitioners holding privileges in a designated clinical practice area.

DEPARTMENT CHIEF is the individual practitioner who is the elected leader of the designated clinical department.

DISTRICT means Northern Inyo Healthcare District (NIHD) and includes all inpatient and outpatient services operated by Northern Inyo Healthcare District.

EX-OFFICIO means service by virtue of office or position held. An ex-officio appointment is without vote unless otherwise specified.

HONORARY STAFF means those former Medical Staff members or other physicians, dentists or podiatrists who do not actively practice at Northern Inyo Healthcare District but are deemed deserving of membership as described in these Bylaws.

IN GOOD STANDING means a member has unrestricted clinical privileges, is currently not under suspension or serving with any limitation of voting or other prerogatives imposed by operation of the Bylaws or policy of the Medical Staff.

INVESTIGATION means a process specifically instigated to determine the validity, if any, to a concern or complaint raised against a practitioner, and does not include activity of the Physician Wellness Committee.

LEAD APP means the elected representative of the Advanced Practice Providers (APPs).

LIMITED LICENSE PRACTITIONER means a practitioner who is not a physician or an APP, but who practices under a license such as a dentist or podiatrist.

MEDICAL EXECUTIVE COMMITTEE means the executive committee of the Medical Staff.

MEDICAL DIRECTOR means the administratively-appointed physician leader of the medical or District department(s) or group(s).

MEDICAL STAFF means those Northern Inyo Healthcare District physicians (MD or DO), dentists, and podiatrists who have been granted recognition as members pursuant to the terms of these Bylaws.

MEDICAL STAFF YEAR means the twelve-month period beginning July 1 through the subsequent June 30.

MEMBER means any physician, dentist, or podiatrist who has been appointed to the Medical Staff.

NOTICE means a written communication delivered personally to the addressee or sent by United States mail, first-class postage prepaid, addressed to the addressee at the last address as it appears in the official records of the Medical Staff or the District.

PHYSICIAN means an individual with an MD or DO degree who is currently licensed to practice medicine.

PRACTITIONER means, unless otherwise expressly limited, any currently licensed physician (MD or DO), limited license practitioner, or Advanced Practice Provider.

PREROGATIVES means the specific governance rights to which a member or APP may be entitled, depending upon the practitioner's category, including without limitation, rights to vote on Medical Staff and Medical Staff committee matters, hold Medical Staff Office, or serve on Medical Staff committees.

PRIVILEGES or CLINICAL PRIVILEGES means the permission granted to a Medical Staff member or APP to render specific patient services.

PROCEDURAL RIGHTS means rights to a hearing and appeal in accordance with Article VII to which a practitioner becomes entitled to as the result of adverse actions taken or recommended which constitute grounds for a hearing.

TELEMEDICINE or TELEHEALTH means the remote diagnosis and treatment of patients by means of telecommunications technology.

UNFAVORABLE ACTION means an action which adversely affects the practitioner but, unlike an adverse action, is not reportable as defined under Business and Professions Code 805.

ARTICLE II: MEMBERSHIP

2.1 NATURE OF MEMBERSHIP

No practitioner, including those in a medical-administrative position by virtue of a contract with the District, shall admit or provide medical or health-related services to patients of Northern Inyo Healthcare District unless the practitioner is a member of the Medical Staff or Advanced Practice Provider with corresponding privileges or has been granted temporary, telemedicine or disaster privileges in accordance with the procedures set forth in these Bylaws.

Appointment to the Medical Staff shall confer only such clinical privileges and rights as have been granted by the Board of Directors in accordance with these Bylaws. Privileges shall be granted and maintained only if the requested privileges are within Northern Inyo Healthcare District's patient care needs.

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2-1 GENERAL QUALIFICATIONS

Membership and privileges shall be extended only to practitioners who are professionally competent and continuously meet the qualifications, standards, and requirements as described in this article.

2.2-2 BASIC QUALIFICATIONS

A practitioner must demonstrate compliance with all basic standards set forth in this Section in order to have an application for Medical Staff membership or privileges accepted for review, except in the instance of appointment to honorary staff. The practitioner must:

(a) Qualify to practice in California as follows:

- (1) Physicians must hold an MD or DO degree or their equivalent and a valid and unrestricted license to practice medicine issued by the Medical Board of California or the California Board of Osteopathic Examiners. For purposes of this Section, "or their equivalent" shall mean any degree (i.e., foreign) recognized by the Medical Board of California or the California Board of Osteopathic Examiner;
- (2) Podiatrists must hold a DPM degree and a valid and unrestricted certificate to practice podiatry issued by the Medical Board of California;
- (3) Dentists must hold a DDS or equivalent degree and a valid and unrestricted license to practice dentistry issued by the California Board of Dental Examiners;

(b) Where applicable to their practice, have a valid and unrestricted federal Drug Enforcement Administration (DEA) certificate.

(c) Have professional liability insurance in not less than ~~\$1M per claim/\$3M aggregate. the minimum amounts as from time to time may be jointly determined by the Board of Directors and Medical Executive Committee.~~

(d) Be board certified or board eligible as determined by the individual service and in the criteria for privileging.

(e) Be eligible to receive payments from the federal Medicare and state Medicaid (Medi-Cal) programs.

(f) If requesting privileges only in departments operated under an exclusive contract, be a member, employee, or subcontractor of the group or person that has the contract.

- (g) Not have been convicted of, or plead guilty or no contest to, a felony related directly to his/her professional practice, or patient relationships, or involving moral turpitude, within the past seven (7) years.

A practitioner who does not meet these basic standards is ineligible to apply for Medical Staff membership or privileges, and the application shall not be accepted for review, except that the honorary Medical Staff do not need to comply with any of the basic standards. If it is determined during processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is not entitled to the procedural rights set forth in these Bylaws.

2.2-3 ADDITIONAL QUALIFICATIONS FOR MEMBERSHIP

In addition to meeting the basic standards, the practitioner must, through the credentialing and privileging processes:

- (a) Demonstrate his or her:

- (1) Adequate education, training and experience in the requested privileges;
- (2) Current professional competence;
- (3) Good judgment; and
- (4) Adequate physical and mental health status to demonstrate to the satisfaction of the Medical Staff that he or she is professionally and ethically competent so that patients can reasonably expect to receive the generally recognized professional level of quality of care.

- (b) Be determined to:

- (1) Adhere to the lawful ethics of his or her profession;
- (2) Work cooperatively with others in the District setting so as to not adversely affect patient care or District operations, as well as abide by the policy on professional conduct and prohibition of disruptive or discriminatory behavior;
- (3) Keep as confidential, as required by law, all information or records received in the physician-patient relationship; and
- (4) Participate in and properly discharge Medical Staff responsibilities.

2.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership or privileges in the Medical Staff merely because that person holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at another health care facility. Medical staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this District.

2.4 NONDISCRIMINATION

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, physical or mental impairment, or sexual orientation if it does not pose a threat to the quality and safety of patient care.

2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for honorary staff, the ongoing responsibilities of each practitioner shall include:

- (a) providing patients with the quality of care meeting the professional standards of the Medical Staff of this District;
- (b) abiding by the Medical Staff Bylaws, applicable Joint Commission (or other applicable accrediting body) standards, and applicable Medical Staff and District policies and procedures, including those related to the security of electronic health records;
- (c) discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership or privileges, including committee assignments, serving as a proctor, or performing peer review;
- (d) preparing and completing in timely fashion medical records for all the patients to whom the practitioner provides care in the District;
- (e) abiding by the ethical principles of the appropriate state medical or other professional association(s);
- (f) working cooperatively with members, nurses, District administration and others so as not to adversely affect patient care, as well as complying with Medical Staff policy on professional conduct;
- (g) making appropriate arrangements for coverage of that member's patients;
- (h) refusing to engage in improper inducements for patient referral;
- (i) participating in and documenting continuing education programs as determined by the Medical Staff for maintenance of privileges;
- (j) discharging such other reasonable staff obligations as may be lawfully established from time to time by the Medical Staff or Medical Executive Committee;
- (k) performing and documenting, if granted the requisite privileges, or arranging for the performance of, a history and physical on every patient he/she admits. As further detailed in Medical Staff policy, a medical history and physical examination shall be completed no more than thirty (30) days before, or twenty-four (24) hours after, admission or registration, but prior to surgery or a procedure requiring anesthesia services. When the medical history and physical examination is completed within thirty (30) days before admission or registration, the physician must complete and document an updated examination of the patient within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The history and physical must be completed and documented by a practitioner in accordance with state law and Medical Staff policy.
- (l) paying applicable dues and/or fees, if required; and
- (m) promptly notifying the Medical Staff Office in writing as soon as reasonably possible, but within 30 days:
 - (1) the initiation of formal proceedings by a medical licensing authority or the DEA to suspend, revoke, restrict or place on probation a license or DEA certificate;
 - (2) an action by the Medical Staff or the governing body of another hospital or health care entity to suspend, revoke, restrict, or deny clinical privileges for reasons related to professional competence or conduct;

- (3) the practitioner's exclusion from participation in Medicare, Medi-Cal or any federal health care program or conviction of a criminal offense related to the provision of health care items or services;
- (4) any formal allegations of fraud or abuse or illegal activity relating to the practitioner's professional practice or conduct made by any State or Federal government agency;
- (5) any report filed with the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank,
- (6) any injury, disability, or illness that would significantly interfere with his/her medical practice;
- (7) the filing of any malpractice claim or action in which the practitioner is a named defendant; or
- (8) any other action that could affect his/her Medical Staff standing and/or clinical privileges at the healthcare District.

Failure to abide by the above-listed duties may result in adverse action.

2.6 CONTRACT PRACTITIONERS

2.6-1 MEMBERSHIP AND PRIVILEGES REQUIRED

A contract practitioner may provide services authorized pursuant to the applicable specified clinical services contract only if the specified clinical services are within the scope of privileges which the contract practitioner has been granted in accordance with these Bylaws. Also, a practitioner who is an employee or subcontractor of a contract practitioner or a medical group or other professional entity which is a party to a contract at the District may be granted temporary privileges to serve as locum tenens for a contract practitioner, provided the practitioner otherwise meets applicable Bylaws requirements for the granting and exercise of such temporary privileges.

2.6-2 EFFECT OF SPECIFIED CLINICAL SERVICES CONTRACT TERMINATION

The termination or expiration of the applicable specified clinical services contract shall automatically terminate only the practitioner's rights to provide services on such basis as specified in the contract, and

- (a) Expressly shall not, of itself, affect the Medical Staff membership or privileges granted to the practitioner, and
- (b) Accordingly, shall not entitle the contract practitioner to procedural rights unless otherwise required by law or expressly provided in the applicable specified clinical services contract.

The affected individual who wishes to maintain Medical Staff membership or privileges after termination of a contract must continue to comply with and adhere to the requirements set forth in these Bylaws. Failure to comply will be deemed a voluntary resignation from Medical Staff membership and privileges. Such deemed resignation shall not entitle the practitioner to procedural rights.

2.6-3 MEDICAL STAFF ROLE IN SPECIFIED CLINICAL SERVICES CONTRACTING

Prior to approving, renewing, or modifying and, to the extent reasonably practical, prior to terminating, a specified clinical services contract, the Board of Directors, Administrator, or Chief Medical Officer shall give notice of the planned action to the Medical Staff by transmitting the notice to the Medical Executive Committee. The Medical Staff and/or the Medical Executive Committee may review and make recommendations to the Board of Directors regarding quality of care issues related to specified clinical services contractual arrangements for physician and/or professional services, prior to the District Board taking final action in the matter.

2.7 ADMINISTRATIVE PRACTITIONERS

Members may be assigned duties by the District Board which are solely administrative in nature, provided that such duties are reasonably related to the member's official Medical Staff responsibilities. The District Board, in its sole discretion, may terminate such assignment at any time. Unless otherwise required by law, such purely administrative service assignment and termination is independent of, and shall have no effect on, the member's membership or privileges, shall not entitle the member to procedural rights, and records of such assignment or termination shall not be deemed part of the member's credentials files or any other Medical Staff records.

ARTICLE III: CATEGORIES OF MEMBERSHIP

3.1 CATEGORIES

The categories of the Medical Staff shall include the following: active, courtesy, consulting, and honorary. At appointment and each time of reappointment, the member's staff category shall be determined.

There are several groups of practitioners who, due to the nature of their practice, do not require assignment to a Medical Staff category. The scope and extent of these practitioners' relationships with the healthcare District can be found in Article IV of these Bylaws.

3.2 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the Credentials Committee, or pursuant to a request by a member under Section 5.6-1(b), or upon direction of the Board of Directors as set forth in Section 6.2-6, the Medical Executive Committee may recommend a change in the Medical Staff category of a member consistent with the requirements of these Bylaws.

3.3 ACTIVE STAFF

3.3-1 QUALIFICATIONS

The active staff shall consist of members who:

- (a) meet the qualifications for membership set forth in Section 2.2;
- (b) when on duty, are located close enough to the healthcare district to provide appropriate quality care, as per the policies of the specific department; and
- (c) are regularly involved in patient care in this healthcare district and regularly involved in Medical Staff functions, as determined by the Medical Staff.

3.3-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

Except as otherwise provided, the rights and responsibilities of an active member shall be to:

- (a) exercise such clinical privileges as are granted pursuant to these Bylaws;
- (b) attend and vote on matters presented at general and special meetings of the Medical Staff and of the department and committees to which the member is duly appointed;
- (c) hold staff or department office and serve as a voting member of committees to which the member is duly appointed or elected by the Medical Staff or duly authorized representative thereof, so long as the activities required by the position fall within the member's scope of practice;
- (d) pay Medical Staff membership dues and application fees in the amount as determined by the Medical Executive Committee; and
- (e) exercise other such rights and responsibilities as outlined in Table 3.8.

3.3-3 TRANSFER OF ACTIVE STAFF MEMBER

After two consecutive ongoing professional practice evaluation (OPPE) cycles as per policy in which a member of the active staff fails to regularly care for patients in this healthcare District or be regularly involved in Medical

Staff functions as determined by the Medical Staff, that member shall be referred to the Credentials Committee to determine the appropriate category, if any, for which the member is qualified.

3.4 COURTESY STAFF

3.4-1 QUALIFICATIONS

The courtesy staff shall consist of members who:

- (a) meet the general qualifications set forth in Section 2.2;
- (b) when on duty, are located close enough to the healthcare district to provide appropriate quality care, as per the policies of the specific department;
- (c) do not utilize this healthcare district as the principle location in their practice and are not regularly involved in Medical Staff functions; and
- (d) are members in good standing of the active Medical Staff of another licensed hospital, and at the time of appointment and reappointment, are able to provide proof of continued membership and privileges at the primary hospital. Exceptions to this requirement may be made by the Medical Executive Committee for good cause.

3.4-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

Except as otherwise provided, the rights and responsibilities of the courtesy staff shall be to:

- (a) care for patients of the healthcare district and exercise such clinical privileges as are granted pursuant to these Bylaws;
- (b) attend meetings of the Medical Staff and the department of which that person is a member, including open committee meetings and educational programs, when available. Courtesy staff have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment;
- (c) provide patient activity and quality review information from his or her primary facility as may be requested at the time of appointment and reappointment;
- (d) pay Medical Staff membership dues and application fees, as determined by the Medical Executive Committee; and
- (e) exercise other such rights and responsibilities as outlined in Table 3.8.

Courtesy staff members shall not be eligible to hold office in the Medical Staff.

3.4-3 LIMITATIONS

Courtesy staff members who regularly admit patients or regularly care for patients at the District shall, upon review of the Credentials Committee and Medical Executive Committee, be obligated to seek appointment to the appropriate staff category.

Courtesy staff members who do not maintain active staff membership at another licensed hospital shall be referred to the Credentials Committee to determine the appropriate category, if any, for which the member is qualified.

3.5 CONSULTING STAFF

3.5-1 QUALIFICATIONS

Any member of the Medical Staff in good standing may consult in that member's area of expertise; however, the consulting Medical Staff shall consist of such practitioners who:

- (a) meet the qualifications set forth in Section 2.2 and are not otherwise members of the Medical Staff;
- (b) possess adequate clinical and professional expertise;
- (c) are called upon periodically by a practitioner at Northern Inyo Healthcare District to render care to patients treated at or admitted to this facility.

3.5-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

The rights and responsibilities of the consulting staff shall be to:

- (a) treat and otherwise care for patients at this facility on request of the patient's practitioner;
- (b) exercise such additional clinical privileges as are granted pursuant to these Bylaws;
- (c) attend meetings of the Medical Staff and the department of which that person is a member, including open committee meetings and educational programs, when available. Consulting staff have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment;
- (d) pay application fees, as determined by the Medical Executive Committee; and
- (e) exercise other such rights and responsibilities as outlined in Table 3.8.

Consulting staff members shall not be eligible to hold office in the Medical Staff.

3.6 HONORARY STAFF

3.6-1 QUALIFICATIONS

The honorary staff shall consist of physicians, dentists, or podiatrists who do not actively practice at the District but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the District, and who continue to exemplify high standards of professional and ethical conduct. Members who have retired from active practice and, at the time of their retirement, were members in good standing of the Medical Staff, and who continue to adhere to appropriate professional and ethical standards, shall also be eligible for appointment to honorary staff upon recommendation of the Medical Executive Committee.

3.6-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

Honorary members are not eligible to admit patients to the hospital or to exercise clinical privileges in the District, or to vote or hold office in this Medical Staff organization, but they may serve upon committees without vote at the discretion of the Medical Executive Committee. They may attend staff and department meetings, including open committee meetings and educational programs. Appointment to honorary staff shall be indefinite, unless otherwise requested by the member.

3.7 GENERAL EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership in the Medical Staff, limited license members (i.e., podiatrists and dentists):

- (a) shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the Chair of the meeting, subject to final decision by the Medical Executive Committee; and
- (b) shall exercise clinical privileges only within the scope of their licensure and as set forth in Section 4.7.

3.8 TABLE OF PREROGATIVES BY MEDICAL STAFF CATEGORY

	Active	Courtesy	Consulting	Honorary
Exercise privileges	Yes	Yes	Yes	No
General voting rights	Yes	No	No	No
Attendance at general Medical Staff meeting required	Yes	No	No	No
May be committee member	Yes	Yes	Yes	Yes
Vote in committee	Yes	No, unless specified at time of appointment to committee	No, unless specified at time of appointment to committee	No
May hold Medical Staff Office	Yes	No	No	No
May be committee Chair	Yes	No	No	No
May be Department Chief	Yes	No	No	No
Pay dues	Yes	Yes	No	No
Pay reappointment application fee	No	Yes	Yes	No
Must have malpractice insurance	Yes	Yes	Yes	No
Must file for reappointment	Yes	Yes	Yes	No

ARTICLE IV: CLINICAL PRIVILEGES

4.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws, a practitioner providing clinical services at this healthcare District shall be entitled to exercise only those clinical privileges specifically granted. Said privileges and services must be within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, and shall be subject to applicable policies and the authority of the Department Chief. Medical staff privileges may be granted or continued by the Board of Directors only upon recommendation of the Medical Staff and following the procedures outlined in these Bylaws. Medical staff privileges may be modified or terminated by the mechanisms as outlined in these Medical Staff Bylaws.

4.2 PRIVILEGE REQUESTS

Each application for privileges must contain a request for the specific clinical privileges desired by the applicant. A request for a modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request.

4.3 LAPSE OF APPLICATION

If a practitioner requesting initial or additional clinical privileges fails to furnish the information necessary to evaluate the request within thirty (30) days (or as otherwise agreed upon), the application shall be regarded as incomplete and lapse as detailed in Section 5.5-4, and the applicant shall not be entitled to a hearing.

4.4 BASIS FOR PRIVILEGE DETERMINATION

Requests for clinical privileges shall be evaluated on the basis of the practitioner's education, training, experience, current demonstrated professional competence and judgment, clinical performance, physical and mental health affecting the ability to perform duties, and the documented results of patient care and other quality review and monitoring as per ongoing and focused professional practice evaluations (OPPE and FPPE). If current competency cannot be demonstrated, an applicant may be eligible for re-entry per the current policy. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges. The decision to grant or deny a privilege and/or to renew an existing privilege shall include peer recommendations which address the applicant's:

1. Patient care
2. Medical/clinical knowledge
3. Practice-based learning and improvement
4. Interpersonal and communication skills
5. Professionalism
6. Systems-based practice

Privileges shall be granted and maintained only if the requested privileges are within the District's patient care needs. Furthermore, no specific privilege may be granted to a practitioner if the task, procedure or activity constituting the privilege is not available within the District despite the practitioner's qualifications or ability to perform the requested privilege, except as provided for under emergency privileges Section 4.11.

4.5 CRITERIA FOR “CROSS-SPECIALTY” OR NEW PRIVILEGES WITHIN THE DISTRICT

Any request for clinical privileges that are new to the District shall initially be reviewed by the appropriate departments and administration in order to establish the need for, and appropriateness of, the new procedure or services. Any request for new clinical privileges that overlap more than one department shall initially be reviewed by the appropriate departments in order to address criteria for the procedure. The Medical Executive Committee shall facilitate the establishment of District-wide credentialing criteria for new or trans-specialty procedures, with the input of all appropriate departments, with a mechanism designed to ensure that quality patient care is provided for by all individuals with such clinical privileges. In establishing the criteria for such clinical privileges, the Medical Executive Committee may establish an ad hoc committee with representation from all appropriate departments.

Further details regarding the development and approval process for new privileges or new services can be found in applicable policy.

4.6 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

4.6-1 FPPE FOR INITIAL PRIVILEGES

(a) General Provisions:

- (1) All initial appointees to the Medical Staff and all practitioners granted new clinical privileges shall be subject to a period of initial review and evaluation as further described in the Medical Staff’s Focused and Ongoing Professional Practice Evaluation (FPPE and OPPE) policy.
- (2) Until an initial appointee has been evaluated for core privileges and released from FPPE for these core privileges, he or she cannot be considered for a Medical Staff leadership position and cannot vote on any Medical Staff issues.

(b) Failure to Complete FPPE:

- (1) If FPPE for core privileges is not completed due to an insufficient amount of clinical activity as per the FPPE and OPPE policy, the practitioner’s membership and privileges will automatically expire, unless otherwise recommended by the Credentials Committee and Medical Executive Committee. Such expiration shall not entitle the practitioner to procedural rights.
- (2) If FPPE for special privileges is not completed due to an insufficient amount of clinical activity, FPPE can be extended as recommended by the proctor(s), the Credentials Committee, and the Medical Executive Committee. In this instance, the practitioner’s core privileges and eligibility for reappointment shall not be affected. Additionally, such extension of FPPE shall not be considered a limitation or restriction of privileges entitling the practitioner to procedural rights.
- (3) If FPPE for any privilege (core or special) is not completed satisfactorily due to competency or quality of care concerns, the relevant privilege, and the membership if the privileges under question are core privileges, may be terminated and/or revoked. In this instance, the practitioner shall be entitled to the procedural rights outlined in these Bylaws.

4.6-2 FPPE ARISING FROM CONCERNS

FPPE may also be initiated when the performance or outcomes of a practitioner are questionable, which may become evident with the occurrence of a single or sentinel event and/or patterns or trends indicating potentially

unsafe patient care. The initiation of FPPE arising from concerns differs from FPPE for new privileges described under Section 4.6-1. Practitioners subject to FPPE arising from concerns may be entitled to procedural rights if such action is a reportable action.

4.7 CONDITIONS FOR PRIVILEGES OF PRACTITIONERS

4.7-1 ADMISSIONS

- (a) The following categories of practitioners are eligible to independently admit patients to the hospital:
 - (1) Physicians (MDs or DOs)
- (b) The following categories of practitioners are eligible to co-admit patients to the hospital:
 - (1) Dentists (non-MD)
 - (2) Podiatrists
 - (3) Certified Nurse Midwives
- (c) Additionally, the following categories of APPs with admitting privileges (as per relevant standardized procedures/protocols) may admit patients upon order of a member of the Medical Staff who has admitting privileges and who maintains responsibility for the overall care of the patient:
 - (1) Physician Assistants
 - (2) Nurse Practitioners

4.7-2 RESPONSIBILITY FOR CARE OF PATIENTS

- (a) The admitting practitioner shall establish at the time of admission, the patient's condition and provisional diagnosis.
- (b) For patients admitted by or upon order of a limited license practitioner, a physician with appropriate privileges must assume responsibility for the care of the patient's medical or psychiatric problems that are present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice.
- (c) Where a dispute exists regarding proposed treatment between a physician member and a practitioner with co-admitting privileges, the physician member's treatment plan shall be the recognized treatment plan.

4.7-3 SURGERY

Surgical procedures performed by limited license practitioners shall be under the overall supervision of the Chief of the department of surgery or his or her designee.

4.8 TEMPORARY CLINICAL PRIVILEGES

Temporary privileges shall not exceed one hundred twenty (120) consecutive days, unless the Medical Executive Committee recommends and the Board of Directors approves a longer period for good cause, and are allowed under two circumstances only: (1) to address a patient care need and (2) to permit patient care to be provided while an application is pending.

4.8-1 PATIENT CARE NEEDS

(a) Care of Specific Patient

Temporary clinical privileges may be granted to a practitioner where good cause exists to provide care to a specific patient or group of patients.

(b) Locum Tenens

Temporary clinical privileges may be granted to a practitioner serving as a locum tenens for a current member of the Medical Staff to meet the care needs of that member's patients or duties in his/her absence.

(c) Other Important Patient Care Needs

Temporary clinical privileges may be granted to allow a practitioner to fulfill an important patient care, treatment, or service need.

4.8-2 PENDING APPLICATION FOR MEDICAL STAFF MEMBERSHIP OR PRIVILEGES

Temporary clinical privileges may be granted to an applicant while his or her application for Medical Staff membership and/or privileges is completed and awaiting review and approval of the Credentials Committee, the Medical Executive Committee or the Board of Directors.

4.8-3 PROCESS FOR GRANTING TEMPORARY CLINICAL PRIVILEGES

Applicants who have qualifications, ability, and judgment consistent with Section 2.2 can qualify to be granted temporary clinical privileges for patient care needs or to permit patient care while an application is pending, provided that:

- (a) The Medical Executive Committee has not made a final recommendation that is adverse or with limitation.
- (b) The applicant has no current or previously successful challenge to professional licensure or registration.
- (c) The applicant has no involuntary termination of Medical Staff membership at any other organization, and no involuntary limitation, reduction, denial or loss of clinical privileges.
- (d) The applicant has no unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment adverse to the applicant.
- (e) The following has been completed:
 - (1) Verification of current California licensure;
 - (2) Verification of the National Practitioner Data Bank report;
 - (3) Verification of relevant training and experience;
 - (4) Verification of current competence and ability to perform the privileges requested.

A decision to grant temporary privileges to an applicant under this Section shall not be binding or conclusive with respect to an applicant's pending request for appointment to the Medical Staff. No practitioner has any right to be granted temporary privileges.

The Administrator is given authority to grant temporary privileges to an applicant. Such action, however, shall be on the recommendation of the following Medical Staff members:

- (1) The applicable clinical Department Chief;
- (2) The Credentials Committee Chairperson; and
- (3) The Chief of Staff.

4.8-4 GENERAL CONDITIONS OF TEMPORARY PRIVILEGES

- (a) If granted temporary privileges, the applicant shall act under the supervision of the Department Chief (or designee) to which the applicant has been assigned.
- (b) Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated or suspended under Articles VI and/or VII of these Bylaws or unless affirmatively renewed. A Medical Staff applicant's temporary privileges shall automatically terminate if the applicant's initial application is withdrawn.
- (c) Notwithstanding any other provision of these Bylaws to the contrary, an applicant shall not be entitled to procedural rights if the applicant's request for temporary privileges is refused, or if all or any portion of the applicant's temporary privileges are suspended, unless such action is a reportable action.
- (d) All persons receiving temporary privileges shall be bound by the Medical Staff Bylaws and policies, and all applicable District policies.

4.9 TELEMEDICINE PRIVILEGES

Practitioners who wish to provide approved types of telehealth services will be credentialed and privileged in accordance with this Section but, unless they separately qualify, apply, and are approved for membership in a staff category described in Article III of these Bylaws, will not be appointed to the Medical Staff in any membership category.

4.9-1 TELEMEDICINE CREDENTIALING

- (a) In processing a request for telemedicine privileges, the Medical Staff may follow the normal credentialing process described in Article V of these Bylaws, including but not limited to the collection of information from primary sources. Alternatively, the Medical Staff may elect to rely upon the credentialing and privileging decisions made by distant-site hospitals and telemedicine entities when making recommendations on privileges for individual distant-site practitioners, subject to meeting the conditions required by law and those specified in these Bylaws.
- (b) Telemedicine privileges shall be for a period not to exceed two (2) years, and shall be subject to re-evaluation and renewal pursuant to the same principles and process described in these Bylaws for the renewal of clinical privileges held by Medical Staff members.
- (c) The direct care or interpretive services provided by the distant-site practitioner must meet the professional standards of the District and its Medical Staff at all times. Distant-site practitioners holding telemedicine privileges shall be obligated to meet all of the basic responsibilities that must be met by members of the Medical Staff, as described in these Bylaws, modified only to take into account their distance from the hospital and the need to pay dues.

- (d) Telemedicine privileges may be denied, restricted, suspended or revoked at the discretion of the Medical Executive Committee or the Chief of Staff acting on its behalf, without hearing rights as described in Article VII of these Bylaws, except as required by law.
- (e) Recognizing that telemedicine physicians may be privileged at many healthcare facilities and entities, the District shall conduct the primary verification procedures for an adequate number of hospitals, health care organizations and/or practice settings with whom the telemedicine physician is or has previously been affiliated in order to ensure current competency. In order to assist in this credentialing and privileging process, the District may request information from the telemedicine physician's primary practice site to assist in evaluation of current competency. The District may also accept primary source verification of credentialing information from the physician's primary practice site or the telemedicine entity to supplement its own primary source verification.

4.9-2 RELIANCE ON DISTANT-SITE ENTITIES

The Medical Staff may rely upon the credentialing and privileging decisions made by a distant-site hospital or distant-site telemedicine entity if the District Board ensures through a written agreement with the distant-site hospital or entity that all of the following provisions are met:

- (a) The distant-site entity acknowledges that it is a contractor of services to this District and, in accordance with 42 CFR §485.635(c)(4)(ii), furnishes services in a manner that permits Northern Inyo Healthcare District to be in compliance with the Medicare Conditions of Participation and appropriate accreditation agencies.
- (b) The distant-site entity is either a Medicare-participating hospital or a lawful provider of the telemedicine services in question, and it confirms that its credentialing and privileging processes and standards for practitioners meet the standards described in the Medicare Conditions of Participation 42 CFR §485.616(c).
- (c) The distant-site entity acknowledges, or the District confirms, that the distant-site entity has a process that is consistent with the credentialing and privileging requirements of the Joint Commission standards for critical access hospitals.
- (d) The individual distant-site practitioner holds privileges at the distant-site entity to provide the services involved, and the distant-site entity provides the District with a current list of the distant-site practitioner's privileges at the distant-site entity.
- (e) The individual distant-site practitioner is licensed in California, or is otherwise authorized by California law, to provide the services at issue, and is covered by professional liability insurance meeting the standards that apply to Medical Staff members at this District as described in these Bylaws.
- (f) The Medical Staff of Northern Inyo Healthcare District performs, and maintains evidence of, peer review of the distant-site practitioners' performance as it relates to District patients and sends the distant-site telemedicine entity such performance information for use in the periodic appraisal of the individual distant-site practitioners. At a minimum, the information this District will provide must include all adverse events that result from the telemedicine services provided by the distant-site practitioners to this District's patients and all complaints this District has received about the distant-site practitioners.

When the District is not a party to a written agreement with a distant-site Medicare participating hospital or distant-site entity containing all of the requirements of the CMS Hospital Conditions of Participation related to distant-site telemedicine credentialing, the telemedicine physician must be credentialed and privileged pursuant to the general credentialing and privileging procedures described in Article V of these Bylaws.

4.10 ADVANCED PRACTICE PROVIDERS

Advanced Practice Providers (APPs) are not eligible for Medical Staff membership, as per California law. They may be granted practice privileges if they hold a license, certificate, or other legal credential in a category of APPs that the Board of Directors (after securing Medical Executive Committee recommendations) has identified as eligible to apply for practice privileges as set forth in Article VIII.

4.11 EMERGENCY PRIVILEGES

In the case of an emergency involving a particular patient, any practitioner with clinical privileges, to the degree permitted by the scope of the applicant's license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of the patient or to save the patient from serious harm provided that the care provided is within the scope of the individual's license or training. Once the emergency has passed or assistance has been made available, further care of the patient shall be assumed by a practitioner of the appropriate department.

4.12 DISASTER PRIVILEGES

In the case of a disaster in which the disaster plan has been activated and the District is unable to handle the immediate patient needs, the following may grant disaster privileges to volunteer practitioners in accordance with the process outlined in the applicable Medical Staff policy:

- (a) the Chief of Staff;
- (b) any physician member of the Medical Executive Committee;
- (c) any Department Chief;
- (d) any active Medical Staff member; or
- (e) designee of any of the above.

The volunteer practitioner shall be required to submit identification and other such required documentation for verification as further detailed in policy. The Medical Staff shall oversee the performance of all volunteer practitioners. Once the care of disaster victims can be adequately assumed by the members of the regular Medical Staff, then disaster privileges of the volunteer will be terminated as further detailed in policy.

ARTICLE V: APPLICATION PROCEDURES FOR PRIVILEGES

5.1 GENERAL

Except as otherwise specified herein, no person (including persons engaged by Northern Inyo Healthcare District in administratively responsible positions) shall exercise clinical privileges in the District or via telemedicine link unless and until that person applies for and receives approval to exercise clinical privileges as set forth in these Bylaws, or, with respect to Advanced Practice Providers, has been granted a service authorization or privileges under applicable Medical Staff policies.

~~A request for an initial application will be reviewed by the Chief of Staff for appropriateness.~~ By applying to the Medical Staff for privileges (or, in the case of members of the honorary staff, by accepting an appointment to that category), the applicant acknowledges responsibility to first review these Bylaws and policies, and agrees to comply with the responsibilities of Medical Staff membership and with the Bylaws and policies of the Medical Staff as they exist and as they may be modified from time to time.

5.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, privileges, or transfer of staff category, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's current competence, character, ethics, and other qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for the Medical Staff's refusal to take action on the application, which shall not be subject to appeal or review under Article VII of these Bylaws. To the extent consistent with law, this burden may include submission to a medical or psychological examination as per relevant credentialing policy, at the applicant's expense, if deemed appropriate by the Medical Executive Committee, which may select the examining physician. If current competency cannot be demonstrated, an applicant may be eligible for re-entry per the current policy.

5.3 APPOINTMENT AND AUTHORITY

The Medical Staff shall make recommendations to the Board of Directors for appointments, denials and revocations of appointments to the Medical Staff as set forth in these Bylaws.

5.4 DURATION OF APPOINTMENT AND REAPPOINTMENT

Initial appointments and reappointments to the Medical Staff shall be for a period of up to two (2) years. Any recommendation for appointment or reappointment of less than two (2) years is at the sole discretion of the Medical Executive Committee and is not subject to rights of appeal as set forth in Article VII.

5.5 APPLICATION FOR INITIAL APPOINTMENT, REAPPOINTMENT, AND PRIVILEGES

5.5-1 APPLICATION FORM

An application form shall be developed by the District and the Medical Staff. The form shall require detailed information which shall include, but not be limited to, information concerning:

- (a) the applicant's qualification, including, but not limited to, professional education, training and experience, current licensure, current DEA registration (if applicable), and continuing medical education information related to the clinical privileges to be exercised by the applicant;
- (b) peer references familiar with the applicant's current professional competence and ethical character;

- (c) requests for membership categories, departments, and clinical privileges;
- (d) past or pending professional disciplinary action, voluntary or involuntary denial, revocation, suspension, reduction or relinquishment of Medical Staff membership or privileges or any licensure or registration, and related matters;
- (e) any past or pending arrests, indictments, criminal charges, or convictions brought against the applicant;
- (f) current physical and mental health status, to the extent necessary to determine the applicant's ability to perform obligations or requested privileges, or as otherwise permitted by law;
- (g) final judgments, settlements, or arbitration awards made against the applicant in professional liability cases, and any filed and served cases pending or dismissed;
- (h) professional liability insurance coverage, in not less ~~than the minimum amounts as from time to time may be jointly determined by the Medical Executive Committee and Board of Directors~~ \$1M per claim/\$3M aggregate; and
- (i) any past, pending or current exclusion or suspension from a state or federal health care program, or any investigation or disciplinary action by any governmental agency relating to the applicant's professional license or practice.

Each application shall be in writing, or electronically submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the applicant. When an applicant requests an application form, that person shall be given a copy of these Bylaws and, as deemed appropriate by the Medical Executive Committee, copies or summaries of any other applicable Medical Staff and District policies relating to clinical practice in the District. Failure to disclose the information requested in the application, or knowingly providing false or misleading information may result in disciplinary action, including suspension or termination of membership and/or privileges, or in a decision that the application does not qualify for credentialing consideration.

5.5-2 EFFECT OF APPLICATION

In addition to the matters set forth in Section 5.1, by submitting an application for privileges, each applicant:

- (a) signifies willingness to appear for interviews in regard to the application;
- (b) authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;
- (c) consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;
- (d) releases from any liability, to the fullest extent provided by law, all persons for their acts performed in connection with investigating and evaluating the applicant;
- (e) releases from any liability, to the fullest extent provided by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;

- (f) consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that the District or Medical Staff may have, and releases the Medical Staff and District from liability for so doing to the fullest extent permitted by law;
- (g) if a requirement then exists for Medical Staff dues, acknowledges responsibility for timely payment;
- (h) agrees to provide quality care for patients;
- (i) pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing for the care of the applicant's patients, seeking consultation whenever indicated, refraining from providing illusory or unnecessary surgical or medical services, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners;
- (j) pledges to be bound by the Medical Staff Bylaws and policies, as well as applicable District policies; and
- (k) agrees that if membership and/or privileges are granted, and for the duration of Medical Staff membership and/or privileges, the applicant has an ongoing and continuous duty to report to the Medical Staff Office as soon as reasonably possible, but within thirty (30) days, any and all information that would otherwise correct, change, modify or add to any information provided in the application or most recent reapplication.

5.5-3 VERIFICATION OF INFORMATION

The applicant shall deliver a completely filled-in, signed, and dated application and supporting documents to the Medical Staff Office and an advance payment of non-refundable Medical Staff dues or fees, if any is required. ~~The Administrator or Chief Medical Officer and Chief of Staff shall be notified of the application.~~ The Medical Staff Office shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. The District's authorized representative shall query the National Practitioner Data Bank regarding the applicant or member and submit any resulting information to the Credentials Committee for inclusion in the applicant's or member's credentials file. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain any reasonably requested information. Failure to provide any requested information within thirty (30) days of a request, or an otherwise agreed to timeframe, shall be deemed a voluntary withdrawal of the application and no further action will be taken with respect to the application. When collection and verification of information is accomplished, all such information shall be transmitted to the Credentials Committee and the appropriate department(s). No final action on an application may be taken until receipt of the Data Bank report.

5.5-4 DETERMINE IF APPLICATION IS COMPLETE

The application will be deemed complete when all required information has been submitted by the applicant and all necessary verifications have been obtained. An application will become incomplete if the need arises for new, additional, or clarifying information at any time prior to final determination by the Board. Notwithstanding any other provision of these Bylaws, an application that is determined to be incomplete shall not qualify for privileging recommendations, regardless of any assessment or determination that may have been made as to its completeness at an earlier stage in the process. Should the applicant fail to make the application complete after thirty (30) days of a request, or an otherwise agreed-to timeframe, the credentialing and privileging process will be terminated. An incomplete application will not be processed. Termination of the credentialing and privileging process under this provision shall not entitle the applicant to any hearing or appeal under Article VII.

5.5-5 DEPARTMENT ACTION

After receipt of the application, the Chief of each department to which the application is submitted shall review the application and supporting documentation, may seek additional information, and may conduct a personal interview with the applicant at the Chief's discretion. The Chief shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges requested, his/her clinical and technical skills, any relevant data available from District performance improvement activities, and the applicant's participation in relevant continuing education. The Chief shall transmit to the Credentials Committee his or her recommendations and, if appointment is recommended, recommendations as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The Chief may also defer action on the application in the event that additional information is needed. In this case, the applicant will be notified and the application will be considered incomplete as described in Section 5.5-4.

5.5-6 CREDENTIALS COMMITTEE ACTION

The Credentials Committee shall review the application, evaluate and verify the supporting documentation, the Department Chief's recommendations, and other relevant information. The Credentials Committee may elect to interview the applicant and seek additional information. As soon as practicable, the Credentials Committee shall transmit to the Medical Executive Committee a written report with its recommendations and, if appointment is recommended, recommendations as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The Credentials Committee may also defer action on the application in the event that additional information is needed. In this case, the applicant will be notified and the application will be considered incomplete as described in Section 5.5-4.

5.5-7 MEDICAL EXECUTIVE COMMITTEE ACTION

At its next regular meeting after receipt of the Credentials Committee report and recommendation, or as soon thereafter as is practicable, the Medical Executive Committee shall consider the report and any other relevant information. The Medical Executive Committee may request additional information, return the matter to the Credentials Committee for further investigation, and/or elect to interview the applicant. The Medical Executive Committee shall immediately forward to the Administrator, for prompt transmittal to the Board of Directors, a written report with its recommendations and, if appointment is recommended, recommendations as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The Medical Executive Committee may also defer action on the application in the event that additional information is needed. In this case, the applicant will be notified and the application will be considered incomplete as described in Section 5.5-4.

5.5-8 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

- (a) Favorable recommendation: When the recommendation of the Medical Executive Committee is favorable to the applicant, it shall be immediately forwarded to the Board of Directors and the supporting documentation shall be made available upon request.
- (b) Unfavorable recommendation: When the recommendation of the Medical Executive Committee is an unfavorable action, in whole or in part, the Board of Directors and the applicant shall be promptly informed by written notice. The applicant shall not be entitled to procedural rights as provided in Article VII.

- (c) Adverse recommendation: When a final recommendation of the Medical Executive Committee is an adverse action, in whole or in part, the Board of Directors and the applicant shall be promptly informed by written notice. The applicant shall be entitled to procedural rights as provided in Article VII. The Board of Directors shall not take action on the pending adverse recommendation until the applicant has exhausted or waived his/her procedural rights.

5.5-9 BOARD OF DIRECTORS ACTION

On favorable recommendation of the Medical Executive Committee:

- (a) A decision of the Board to adopt a favorable recommendation of the Medical Executive Committee shall be deemed as final action.
- (b) If the Board is inclined to reject or modify a favorable recommendation, the Board shall refer the matter to the Joint Conference Committee.
- (c) If the Board's resolution constitutes grounds for a hearing under Article VII of the Bylaws, the Administrator shall promptly inform the applicant and the Chief of Staff, and the applicant shall be entitled to the procedural rights as provided in that Article. Once the applicant has exhausted or waived his/her procedural rights, the Board may then take final action.

On adverse recommendation of the Medical Executive Committee:

- (a) Once the applicant has exhausted or waived his or her procedural rights, the Board may take final action in the matter or refer the matter to the Joint Conference Committee.

5.5-10 NOTICE OF FINAL DECISION

- (a) Notice of the final decision shall be given to the applicant, the Chief of Staff, the Chief of each department concerned, and the Administrator if not previously informed.
- (b) A decision and notice to appoint or reappoint shall include, if applicable: (1) the staff category to which the applicant is appointed; (2) the department to which that person is assigned; (3) the clinical privileges granted; and (4) any special conditions attached to the appointment.

5.5-11 REAPPLICATION AFTER ADVERSE OR UNFAVORABLE ACTION

An applicant who has received a final adverse action, as defined in these Bylaws, regarding an application for appointment, reappointment, or privileges shall not be eligible to reapply to the Medical Staff for a period of three (3) years. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

An applicant who has received an unfavorable action, as defined in these Bylaws, is eligible to reapply once the deficiency has been corrected. The waiting period shall not apply.

5.5-12 TIMELY PROCESSING OF APPLICATIONS

Once an application is deemed complete, it is expected to be processed within one hundred twenty (120) days, unless it becomes incomplete at any point during processing as described in these Bylaws. This time period is provided to assist in the processing of the application and not to create rights for applicants to have their applications processed within this specific time period.

5.6 REAPPOINTMENT AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

Applicants for reappointment, renewal of privileges, and requests for modifications of staff status or privileges shall be subject to all of the general application provisions of these Bylaws and to the following additional provisions:

5.6-1 REAPPLICATION DEADLINE AND CONTENT

- (a) At least one hundred fifty (150) days prior to the expiration date of the current staff appointment or expiration of privileges for privileges-only practitioners (for example, telemedicine), a reapplication form shall be submitted to the member or privileged practitioner. At least one hundred twenty (120) days prior to the expiration date, each applicant shall submit to the Medical Staff Office the completed application form for renewal of appointment to the staff and for renewal or modification of clinical privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant. However, an applicant for reappointment shall not be required to repeat information which has been provided and verified in a prior application and in which there has been no change during the period since the applicant submitted the prior application. For such information, in response to each relevant portion of the application form, the applicant shall indicate that the information is unchanged.
- (b) A Medical Staff member or privileged practitioner who seeks a change in Medical Staff status or modification of clinical privileges may submit such a request at any time.
- (c) The timely processing of reapplications from receipt of the application to final action shall be one hundred twenty (120) days.

5.6-2 FAILURE TO FILE REAPPOINTMENT APPLICATION

If an application for reappointment is not received at least one hundred twenty (120) days prior to the expiration date, written notice shall be promptly sent to the applicant advising that the application has not been received. The applicant may submit a request for extension to the Medical Executive Committee for consideration.

If an applicant fails, without good cause, to submit the required application by the deadline, but submits it prior to the expiration date of the applicant's privileges, and no final decision has been rendered by the expiration date due to the delays caused by the applicant's failure to timely submit the complete application, the applicant's privileges and prerogatives shall be deemed to be automatically suspended upon the expiration date unless otherwise extended by the Medical Executive Committee with the approval of the Board of Directors. The automatic suspension shall remain in effect until the District Board makes a final decision on the application.

If an applicant fails, without good cause, to submit the required reappointment application by the expiration date of the applicant's privileges, or to provide information requested to complete the application after receiving a notice of incomplete application, the applicant shall be deemed to have voluntarily resigned from membership and relinquished all privileges, effective as of the expiration date of the applicant's term of appointment and/or privileges.

In the event membership terminates and/or privileges lapse for the reasons set forth herein, the procedures set forth in Article VII shall not apply.

5.7 LEAVE OF ABSENCE

A practitioner taking any of the following leaves of absence for a duration exceeding ninety (90) days must notify the Medical Staff Office prior to the start of leave, stating the approximate period of leave desired, which may not exceed one (1) year. Absence for longer than one (1) year shall result in automatic expiration of Medical Staff appointment and clinical privileges, unless an extension is requested in writing at least forty-five (45) days prior to the one-year date and granted by the Medical Executive Committee. Reinstatement from any leave shall be subject to the provisions listed in Section 5.7-5.

5.7-1 ROUTINE LEAVE OF ABSENCE

A practitioner may take a routine leave of absence, giving consideration to his/her contractual obligations. The Medical Executive Committee shall be notified of the leave.

5.7-2 MEDICAL LEAVE OF ABSENCE

A practitioner may take a medical leave of absence to accommodate treatment for, or recovery from, a behavioral health or physical health condition affecting his or her fitness to practice safely. The approximate period of leave needed shall be specified, and as reasonable during the leave, the Medical Executive Committee shall be kept informed of changes to the projected date of return. The practitioner may be required to submit a letter of release from the treating physician as part of the reinstatement process confirming that his or her health is free from any impairment prior to exercising any patient care. The Medical Executive Committee may, at its discretion, require a fit for duty evaluation be performed by a provider of its choosing and at the practitioner's cost.

5.7-3 MILITARY LEAVE OF ABSENCE

A practitioner may request a leave of absence to fulfill military service obligations. Such request shall be granted upon notice and review by the Medical Executive Committee.

5.7-4 OBLIGATION UNDER LEAVE OF ABSENCE

During the period of the leave, the practitioner shall not exercise clinical privileges at Northern Inyo Healthcare District, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the Medical Executive Committee.

Before any routine leave of absence may begin, all medical records must be completed and dues must be current, unless such dues are excused by the Medical Executive Committee. Meeting attendance requirements will be waived during the period of leave.

5.7-5 REQUEST FOR REINSTATEMENT

At least forty-five (45) days prior to the termination of the leave of absence or as soon as reasonably known, the practitioner may request reinstatement of privileges by submitting a written notice to the Medical Executive Committee (and in the case of an Advanced Practice Provider, written notice to the Interdisciplinary Practice Committee in addition to the Medical Executive Committee). The Medical Executive Committee shall make a recommendation concerning the reinstatement of the practitioner's privileges and prerogatives, which may take into consideration a summary of the practitioner's activities during the leave. Reinstatement may be granted subject to focused professional practice monitoring and/or evaluation as determined by the Medical Executive Committee. A recommendation that a practitioner be denied reinstatement shall be considered a denial of privileges and may be appealed as such pursuant to these Bylaws.

5.7-6 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff or Advanced Practice Provider staff and shall result in automatic expiration of membership, privileges, and prerogatives. A practitioner whose membership and/or privileges automatically expires under this provision may contest this action to the Medical Executive Committee by submitting a written statement or request a meeting before the committee. The Medical Executive Committee's decision on the matter shall be final. A request for membership and/or privileges subsequently received from a member terminated under this provision shall be submitted and processed in the manner specified in these Bylaws for initial appointments.

5.7-7 EXPIRATION OF APPOINTMENT WHILE ON LEAVE

If a practitioner's term of appointment is scheduled to expire during the period for which a leave is requested, the practitioner may:

- (a) Seek and obtain reappointment prior to going on leave, which would result in an adjustment of the practitioner's subsequent term of appointment to reflect the new date of reappointment. The Medical Staff may require that supplemental information be produced to confirm current competence upon reinstatement; or
- (b) Apply for reappointment at the scheduled time while on leave. The Medical Staff may require that supplemental information be produced to confirm current competence upon reinstatement; or
- (c) Permit the current term of appointment to expire and reapply for membership and/or privileges as an initial applicant once the leave of absence has ended.

ARTICLE VI: PEER REVIEW AND CORRECTIVE ACTION

6.1 MONITORING AND PEER REVIEW

Medical staff departments and committees are responsible for carrying out delegated peer review and quality assessment functions as per applicable peer review and quality policies. They may counsel, educate, issue letters of warning or censure, or initiate focused review or retrospective or concurrent monitoring (so long as the practitioner is only required to provide reasonable notice of admission and procedures) without initiating an investigation or formal corrective action. Comments, suggestions, and warnings may be issued orally or in writing. Informal actions, focused review, monitoring or counseling shall be documented in the practitioner's file and reviewed as part of their ongoing professional practice evaluation. Medical Executive Committee approval is not required for such actions, but the Medical Executive Committee shall be notified if trends or concerns are noted. Such routine peer review and quality assessment functions shall not constitute an investigation and shall not constitute a restriction of privileges or grounds for any formal hearing or appeal rights as described in Article VII of these Bylaws.

6.2 CORRECTIVE ACTION

Corrective action is separate from routine monitoring and peer review and can be initiated at any time as outlined in this Section. A practitioner is not required to have exhausted all monitoring and peer review activities prior to initiation of a corrective action. It is recommended that Medical Staff legal counsel be consulted in corrective action proceedings.

6.2-1 CRITERIA FOR INITIATION

Any person may provide information to the Medical Staff Office or officer of the Medical Staff about the conduct, performance, or competence of its members and practitioners, who will then take this information to the Department Chief, the Chief of Staff or Medical Executive Committee. When reliable information indicates a practitioner may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the District; (2) unethical; (3) contrary to the Medical Staff Bylaws; or (4) below applicable professional standards, an investigation or request for action may be initiated.

6.2-2 INITIATION

A request for an investigation or action against such practitioner may be initiated by the Chief of Staff or the Medical Executive Committee. The request must be submitted to the Medical Executive Committee, and supported by reference to specific activities or conduct alleged. If the Medical Executive Committee initiates the request, it shall make an appropriate recording of the reasons in the minutes.

6.2-3 INVESTIGATION

If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself, or may assign the task to an ad hoc committee of the Medical Staff. If an ad hoc committee is formed, the Chief of Staff shall appoint the members of the ad hoc committee with the recommendation of the Medical Executive Committee. If the investigation is delegated to an officer or committee other than the Medical Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action. The affected practitioner shall be promptly notified by the Chief of Staff that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The body investigating the matter may, but is not obligated to:

- (a) conduct interviews with persons involved; however, such investigation shall not constitute a “hearing” as that term is used in Article VII, nor shall the procedural rules with respect to hearings or appeals apply; and
- (b) review the practitioner’s file.

Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

6.2-4 EXECUTIVE COMMITTEE ACTION

As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall take action which may include, without limitation:

- (a) determining no corrective action be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the practitioner’s file;
- (b) referring the practitioner to the Physician Wellness Committee for evaluation and follow-up as appropriate;
- (c) deferring action for a reasonable time where circumstances warrant;
- (d) issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude committees or departments or their Chiefs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected practitioner may make a written response which shall be placed in his or her file;
- (e) recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring;
- (f) recommending reduction, modification, suspension or revocation of clinical privileges;
- (g) recommending reductions of membership status or limitation of any prerogatives directly related to the practitioner’s delivery of patient care;
- (h) recommending suspension, revocation or probation of Medical Staff membership; and
- (i) taking other actions deemed appropriate under the circumstances.

6.2-5 SUBSEQUENT ACTION

If the Medical Executive Committee has imposed or recommended corrective action as to which the affected practitioner may request a hearing, the Board of Directors shall be advised of the action ~~and hearing request at~~ the next regularly scheduled meeting after notification to the practitioner.

6.2-6 INITIATION BY BOARD OF DIRECTORS

If the Medical Executive Committee fails to investigate or take disciplinary action in response to information about a practitioner’s competence, performance, or conduct that is provided in accordance with the provisions of this Article, and if the Board of Directors determines that the Medical Executive Committee’s failure to proceed is contrary to the weight of the evidence, the Board of Directors may direct the Medical Executive

Committee to initiate investigation or disciplinary action. The Board's request for Medical Staff action shall be in writing and shall set forth the basis for the request.

If the Medical Executive Committee fails to take action in response to such direction from the Board of Directors, then the Board may initiate the dispute resolution process as described in the Joint Conference Committee of these Bylaws (unless immediate action is required to protect the health or safety of any individual, in which event the procedures for summary suspension shall apply). If the dispute resolution process does not result in action by the Medical Executive Committee, and the Board of Directors still believes action is necessary, then the Board of Directors may initiate an investigation or corrective action after written notice to the Medical Executive Committee, and shall fully comply with Articles VI and VII of these Medical Staff Bylaws.

6.3 SUMMARY RESTRICTION OR SUSPENSION

6.3-1 CRITERIA FOR INITIATION

Whenever a practitioner's conduct is such that failure to take action may result in an imminent danger to the health of any individual, including but not limited to current or future patients, the Chief of Staff, the Medical Executive Committee, or the Chief of the department in which the practitioner holds privileges may summarily restrict or suspend the Medical Staff membership or clinical privileges of such practitioner. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the Board of Directors, the Medical Executive Committee, the Medical Staff Office, the Chief Medical Officer and the Administrator. In addition, the affected practitioner shall be provided with a written notice of the action that fully complies with the requirements of Section 6.3-2 below. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the practitioner's patients shall be promptly assigned to another practitioner by the Department Chief or by the Chief of Staff, considering where feasible, the wishes of the patient in the choice of a substitute practitioner. Summary suspension or restriction shall automatically constitute a request for investigation pursuant to this Article.

6.3-2 NOTICE OF SUMMARY SUSPENSION

The affected practitioner shall be promptly provided with written notice of such suspension within two (2) business days. This initial written notice shall generally describe the reasons for the action, the extent of the action, and the effective date and time of the action. Oral notice of summary suspension may be provided immediately to the affected practitioner and prior to the written notice if needed in order to assure patient safety.

This initial notice shall not substitute for, but is in addition to, the notice required under Section 7.3-1 (which applies in all cases where the Medical Executive Committee does not immediately terminate the summary suspension). The notice under Section 7.3-1 may supplement the initial notice provided under this Section, by including any additional relevant facts supporting the need for summary suspension or other corrective action.

6.3-3 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as reasonably possible under all circumstances after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee shall be convened to review and consider the action. Upon request, the affected practitioner may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the practitioner, constitute a "hearing" within the meaning of Article VII, nor shall any procedural rules apply. The Medical Executive

Committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the practitioner with notice of its decision within two (2) working days of the meeting. A copy of the notice shall be given to the Administrator, the Chief Medical Officer, the District Board, and the relevant Department Chief.

6.3-4 PROCEDURAL RIGHTS

Unless the Medical Executive Committee promptly terminates the summary restriction or suspension, it shall remain in effect during the pendency of the corrective action, hearing and appeal process, and the practitioner shall be entitled to the procedural rights afforded by Article VII.

6.3-5 INITIATION BY BOARD OF DIRECTORS

If the Chief of Staff, members of the Medical Executive Committee and the Chief of the department in which the practitioner holds privileges are not available to summarily restrict or suspend the practitioner's membership or clinical privileges, the Board of Directors (or the Administrator on-call, as designee) may immediately suspend a practitioner's privileges if a failure to suspend those privileges is likely to result in an imminent danger to the health of any person, provided that the Board of Directors (or Administrator on-call) made reasonable attempts to contact the Chief of Staff, members of the Medical Executive Committee and the Chief of the department before the suspension.

A suspension under this Section is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within two (2) business days, the summary suspension shall terminate automatically. If the Medical Executive Committee does ratify the summary suspension, all other provisions under Section 6.3 of these Bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the Medical Executive Committee for purposes of compliance with notice and hearing requirements.

6.4 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the practitioner's privileges or membership may be suspended or limited as described, with no right to hearing unless reportable by law to the Medical Board of California. However, the practitioner may appear before the Medical Executive Committee or submit a written statement addressing the question of whether grounds exist for the special action as set forth below. A practitioner may be eligible to reapply for reinstatement of privileges if the cause for such automatic action has been resolved.

6.4-1 LICENSURE

- (a) Revocation and Suspension: Whenever a practitioner's license or other legal credential authorizing practice in this state is revoked or suspended, Medical Staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.
- (b) Restriction: Whenever a practitioner's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the practitioner has been granted which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.
- (c) Probation: Whenever a practitioner is placed on probation by the applicable licensing or certifying authority, membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

- (d) Expiration: Whenever a practitioner's license is expired or evidence of renewal has not been received, the practitioner shall be automatically suspended until such time as evidence of current licensure has been received. Failure to reinstate such license or other legal credential within thirty (30) days of such lapse or expiration shall result in automatic termination of Medical Staff membership and/or clinical privileges.

6.4-2 DRUG ENFORCEMENT ADMINISTRATION (DEA) CERTIFICATE

- (a) Whenever a practitioner's DEA certificate is revoked, limited, expired, or suspended, the practitioner shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.
- (b) Probation: Whenever a practitioner's DEA certificate is subject to probation, the practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

6.4-3 MEDICAL RECORDS

Members of the Medical Staff and other clinically privileged practitioners are required to complete medical records within such reasonable time as may be prescribed by the District and the Medical Staff. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed may be imposed by the Chief of Staff after notice of delinquency for failure to complete medical records within such period has been given to the practitioner. For the purpose of this Section, "related privileges" means voluntary on-call service for the emergency room, scheduling surgery, assisting in surgery, consulting on hospital cases, and providing professional services within Northern Inyo Healthcare District. Bona fide leave may constitute an excuse subject to approval by the Medical Executive Committee. Practitioners whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until lifted by the Chief of Staff or his or her designee. If within ninety (90) days after implementation of suspension the practitioner has not completed the delinquent records, the practitioner's membership and privileges shall be automatically terminated without right to a hearing unless reportable by law.

6.4-4 PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance in the amounts indicated shall result in an automatic suspension of a practitioner's clinical privileges, and if within ninety (90) days after written warning of the delinquency the practitioner does not provide evidence of required professional liability insurance and evidence of coverage for the interim, the practitioner's membership and privileges shall be automatically terminated without right to a hearing unless reportable by law.

6.4-5 FAILURE TO PROVIDE INFORMATION OR SATISFY SPECIAL ATTENDANCE REQUIREMENT

Failure without good cause to provide information or appear when requested by a Medical Staff committee or department as described in these Bylaws shall result in the referral to the Medical Executive Committee for action, which may include automatic suspension of all privileges. The automatic suspension shall remain in effect until the practitioner has provided the requested information and/or satisfied the special attendance requirement.

6.4-6 FELONY CONVICTION OR PLEA

A practitioner who has been convicted of, or who has pleaded guilty or no contest to, a felony ~~within the past seven (7) years~~ shall not be eligible for privileges or initial appointment to the Medical Staff unless the Medical Executive Committee determines, in its sole discretion, the felony was not directly related to the practitioner's professional practice or patient relationships.

If a practitioner of the Medical Staff is convicted of, or pleads guilty or no contest to a felony, the practitioner's Medical Staff membership and privileges shall be automatically suspended pending review by the Medical Executive Committee. If the Medical Executive Committee, in its sole discretion, confirms that the felony was directly related to the practitioner's professional practice or patient relationships or involving moral turpitude, the practitioner's staff membership and privileges shall terminate without right to a hearing. If the Medical Executive Committee determines, in its sole discretion, the felony was not directly related to the practitioner's professional practice or patient relationships, the practitioner shall be permitted to request reinstatement as an initial applicant.

6.4-7 EXCLUSION FROM GOVERNMENTAL PROGRAM

A practitioner who is excluded as a provider from any governmental health care program (including but not limited to Medicare and Medi-Cal) may not apply for initial appointment to the Medical Staff. If a privileged practitioner is excluded as a provider from such governmental program during their appointment, the practitioner's Medical Staff membership and privileges shall be automatically terminated without right to a hearing.

6.4-8 NOTICE OF AUTOMATIC ACTION

No notice shall be required for an automatic action to become effective. However, as soon as reasonably practical after the automatic action becomes effective, written notice shall be provided to the affected practitioner, the Administrator, the Chief Medical Officer, the Department Chief, and the Chief of Staff.

6.4-9 MEDICAL EXECUTIVE COMMITTEE DELIBERATION

As soon as practicable after automatic action is taken or warranted, the Medical Executive Committee shall convene to review and consider the facts, and may recommend any further corrective action as it may deem appropriate in accordance with these Bylaws.

ARTICLE VII: HEARINGS AND APPELLATE REVIEWS

7.1 GENERAL PROVISIONS

7.1-1 PROCESS TO CHALLENGE ADVERSE ACTIONS REPORTABLE UNDER BUSINESS AND PROFESSIONS CODE SECTION 805

The notice, hearing and appeal provisions available to a practitioner to contest an action or final recommended action which must be reported to the Medical Board of California under Business and Professions Code Section 805 shall be governed by the provisions of this Article commencing with Section 7.2 below.

7.1-2 PROCESS TO CHALLENGE UNFAVORABLE ACTIONS NOT REPORTABLE UNDER BUSINESS AND PROFESSIONS CODE SECTION 805

A practitioner who is adversely and significantly affected by an unfavorable action or recommended action for which a review process is not otherwise provided in these Bylaws or in policies, and which is not reportable under Business and Professions Code Section 805, may contest such actions or recommended actions by delivering a written request for review to the Medical Executive Committee. In no event shall any meeting of the Medical Executive Committee, with or without the practitioner, constitute a hearing within the meaning of Article VII, nor shall any procedural hearing rights apply. If the action or recommended action was made by the Board of Directors, the practitioner may contest the matter by providing written request for review to the Board of Directors. Any such request for review must be delivered within thirty (30) days from the practitioner's receipt of notice of the action or recommendation.

Examples of matters reviewable under this Section include, without limitation, restriction of clinical privileges for less than thirty (30) days in a twelve (12) month period; summary suspension of clinical privileges for fourteen (14) days or less; and termination, denial or restriction of privileges or membership rights for reasons other than medical disciplinary cause as defined in Business and Professions Code Section 805.

7.1-3 DUTY TO EXHAUST INTERNAL REMEDIES

All practitioners and applicants are obligated to exhaust all remedies provided in this Article or elsewhere in Medical Staff Bylaws before initiating legal action. Any practitioner who fails to exhaust the remedies (including all hearing and appeal remedies) provided in these Bylaws before initiating legal action, shall be liable to pay the full costs, including legal fees, required to respond to such legal action.

7.1-4 TIMELY COMPLETION OF PROCESS

The hearing and appeal process shall be completed within a reasonable time.

7.1-5 FINAL ACTION

Recommended adverse actions described in Section 7.2 shall become final only after the hearing and appellate rights set forth in these Bylaws have either been exhausted or waived, and only upon being adopted as final actions by the Board of Directors.

7.2 GROUNDS FOR HEARING

Except as otherwise specified in these Bylaws, any one or more of the following adverse actions shall constitute grounds to request a hearing:

- (a) denial of initial Medical Staff appointment or requested reappointment to the Medical Staff, based on professional competence or conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care;
- (b) denial of requested clinical privileges based on professional competence or conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care;
- (c) summary suspension of staff membership or staff privileges for greater than fourteen (14) days;
- (d) termination or revocation of Medical Staff membership or clinical privileges based on professional competence or conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care;
- (e) involuntary reduction or restriction of clinical privileges or membership for thirty (30) days or more in any twelve (12) month period; or
- (f) any other disciplinary action or recommendation that must be reported, by law, to the practitioner's California licensing authority under Business and Professions Code Section 805.

7.3 REQUESTS FOR HEARING

7.3-1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which action has been taken or a recommendation made as set forth in Section 7.2, the practitioner shall be given prompt written notice of:

- (a) the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the Medical Board of California and/or to the National Practitioner Data Bank, if required;
- (b) a brief description of the reasons for the proposed action;
- (c) the right to request a hearing pursuant to Section 7.3-3, and that such hearing must be requested in writing within thirty (30) days; and
- (d) a summary of the rights granted in the hearing pursuant to the Medical Staff Bylaws.

7.3-2 HEARINGS PROMPTED BY BOARD OF DIRECTORS ACTION

If the hearing is based upon an adverse decision or recommendation of the Board of Directors, the Board of Directors or its designee shall fulfill the duties assigned to the Medical Executive Committee or the Chief of Staff when the Medical Executive Committee is the body whose decision prompted the hearing. This shall include, but not be limited to, preparing the notice of adverse action or recommended action and right to a hearing, scheduling the hearing, providing the notice of hearing and statement of charges, and designating the Judicial Review Committee, presenter and witnesses.

7.3-3 REQUEST FOR HEARING

The practitioner shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the ~~Medical Executive Committee~~ Chief of Staff with a copy to the Medical Executive Committee, Administrator, Chief Medical Officer, and Board of Directors. Any such request shall include the practitioner's intent with regard to representation. In the event the practitioner does not request a hearing within the time and in the manner described, the practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

7.3-4 TIME AND PLACE FOR HEARING

Upon receipt of a request for hearing, the Medical Executive Committee has thirty (30) days to schedule a hearing. The Medical Executive Committee will give notice to the practitioner of the time, place and date of the hearing. The date of the commencement of the hearing shall not be more than sixty (60) days from the date of receipt of the request by the Medical Executive Committee for a hearing, so long as the practitioner has at least thirty (30) days from the date of notice to prepare for the hearing, or both parties mutually agree to an earlier date. When the request is received from a practitioner who is under summary suspension the hearing shall be held as soon as the arrangements may reasonably be made.

7.3-5 NOTICE OF HEARING AND NOTICE OF REASONS OR CHARGES

Together with the notice stating the place, time and date of the hearing, the Chief of Staff or designee on behalf of the Medical Executive Committee shall provide the reasons for the recommended action, including the acts or omissions with which the practitioner is charged and a list of the charts in question, where applicable.

7.3-6 JUDICIAL REVIEW COMMITTEE

When a hearing is granted, the Medical Executive Committee shall recommend a Judicial Review Committee. The Judicial Review Committee shall be composed of not less than three (3) members of the active Medical Staff. The Judicial Review Committee members shall be unbiased, shall gain no direct financial benefit from the outcome, and shall not have acted as accusers, investigators, fact finders, initial decision-makers or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Judicial Review Committee. In the event that it is not feasible to appoint a Judicial Review Committee from the active Medical Staff, the Medical Executive Committee may appoint members from other staff categories or practitioners who are not members of the Medical Staff. Such appointment shall include designation of the Chair. The Judicial Review Committee shall consist of one member who shall have the same healing arts licensure as the accused, and where feasible, include an individual practicing the same specialty as the practitioner. All other Judicial Review Committee members shall have MD or DO degrees or equivalent license.

7.3-7 FAILURE TO APPEAR OR PROCEED

Failure without good cause of the practitioner to personally attend and proceed at such a hearing in an efficient and orderly manner shall be grounds for termination of the hearing and shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

7.3-8 POSTPONEMENTS AND EXTENSIONS

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted by the officer presiding over the hearing on a showing of good cause, or upon agreement of the parties.

7.4 HEARING PROCEDURE

7.4-1 PREHEARING PROCEDURE

- (a) Not less than fifteen (15) days prior to the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence in support of that party at the hearing. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the

possible participation of such additional witnesses. Failure to provide the name of any witness at least ten (10) days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

- (b) The practitioner may inspect and copy, at their expense, any documentary information relevant to the charges that the Medical Executive Committee has in its possession or under its control. The Medical Executive Committee may inspect and copy, at its expense, any documentary information relevant to the charges that the practitioner has in their possession or under their control. Requests for discovery shall be met as soon as practicable. Failure to comply with reasonable discovery requests at least thirty (30) days prior to the hearing shall be good cause for a continuance of the hearing. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable practitioners, other than the practitioner under review.
- (c) The practitioner and the Medical Executive Committee shall exchange all evidence which will be made available to the Judicial Review Committee and introduced at the hearing. Failure to produce copies of all documents expected to be produced at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance.
- (d) The hearing officer (see Section 7.4-3) shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the hearing officer shall consider:
 - (1) whether the information sought may be introduced to support or defend the charges;
 - (2) the exculpatory or inculpatory nature of the information sought, if any;
 - (3) the burden imposed on the party in possession of the information sought, if access is granted; and
 - (4) any previous requests for access to information submitted or resisted by the parties to the same proceeding.
- (e) The practitioner shall be entitled to a reasonable opportunity to question and challenge the impartiality of Judicial Review Committee members and the hearing officer. Challenges to the impartiality of any Judicial Review Committee member shall be ruled on by the hearing officer. Challenges to the impartiality of the hearing officer shall be ruled on by the hearing officer.
- (f) It shall be the duty of the practitioner and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the Chair of the Judicial Review Committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions may be succinctly made at the hearing.

7.4-2 REPRESENTATION

The hearings provided for in these Bylaws are for the purpose of intraprofessional resolution of matters bearing on professional conduct, professional competency, or character. The parties may be represented by legal counsel.

In all instances, the Chief of Staff or another physician designated by the Medical Executive Committee shall have the authority to:

- (a) be present during all phases of the hearing process;

- (b) to make decisions regarding the detailed contents of the notice of reasons or charges;
- (c) to make decisions regarding the presentation of testimony and exhibits;
- (d) to direct the activities of the Medical Executive Committee's attorney, if any;
- (e) to consult with prospective and designated witnesses for the Medical Executive Committee; and
- (f) to amend the notice of reasons or charges as he or she seems warranted during the course of the proceedings, subject to the practitioner's procedural rights.

However, the Medical Executive Committee's representative shall not have the authority to modify the nature of the Medical Executive Committee's action or recommendation without the Medical Executive Committee's approval.

7.4-3 THE HEARING OFFICER

The Medical Executive Committee shall recommend a hearing officer to preside at the hearing. The hearing officer shall be an attorney-at-law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the District, the Medical Staff or the involved practitioner or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve as hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances, in accordance with California law. If requested by the Judicial Review Committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

7.4-4 RECORD OF THE HEARING

A court reporter shall be present to make a thorough and accurate record of the hearing proceedings, and the prehearing proceedings, if deemed appropriate by the hearing officer. The cost of attendance of the recorder shall be borne by the District, but the cost of the transcript, if any, shall be borne by the party requesting it. The Judicial Review Committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by a person lawfully authorized to administer such oath.

7.4-5 RIGHTS OF THE PARTIES

Within reasonable limitations, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The practitioner may be called by the Medical Executive Committee (or its designee) and examined as if under cross-examination.

7.4-6 MISCELLANEOUS RULES

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence,

including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely on in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the Judicial Review Committee may request both sides to file written arguments. The hearing process shall be completed within a reasonable time after the notice of the action is received, unless the hearing officer issues a written decision that the practitioner or the Medical Executive Committee failed to provide information in a reasonable time or consented to the delay.

7.4-7 BURDENS OF PRESENTING EVIDENCE AND PROOF

- (a) At the hearing the Medical Executive Committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The practitioner may present evidence in response.
- (b) An applicant shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, of the applicant's qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning the applicant's current qualifications for membership and privileges. An applicant shall not be permitted to introduce information requested by the Medical Staff but not produced during the application process or corrective action proceedings, unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.
- (c) Except as provided above for applicants, throughout the hearing, the Medical Executive Committee shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.

7.4-8 ADJOURNMENT AND CONCLUSION

After consultation with the Chair of the Judicial Review Committee, the hearing officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Both the Medical Executive Committee and the practitioner may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

7.4-9 BASIS FOR DECISION

The decision of the Judicial Review Committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision of the Judicial Review Committee shall be subject to such rights of appeal as described in these Bylaws.

7.4-10 DECISION OF THE JUDICIAL REVIEW COMMITTEE

Within thirty (30) days after final adjournment of the hearing, the Judicial Review Committee shall render a decision which shall be accompanied by a report in writing and shall be delivered to the Medical Executive Committee. If the practitioner is currently under suspension, however, the time for the decision and report shall be fifteen (15) days. A copy of said decision also shall be forwarded to the Administrator, the Chief Medical Officer, the Board of Directors, and to the practitioner. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. Both the practitioner and the Medical Executive Committee shall be provided a written explanation of the procedure for appealing the

decision. The decision of the Judicial Review Committee shall be subject to such rights of appeal or review as described in these Bylaws.

7.5 APPEAL

7.5-1 TIME FOR APPEAL

Within ten (10) days after receipt of the decision of the Judicial Review Committee, either the practitioner or the Medical Executive Committee may request an appellate review. A written request for such review shall be delivered to the Chief of Staff, the Administrator, the Chief Medical Officer, the other party in the hearing, and a copy provided to the Board of Directors. If a request for appellate review is not requested within such period, that action or recommendation shall thereupon become the final action of the Medical Staff.

7.5-2 GROUNDS FOR APPEAL

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be:

- (a) substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice;
- (b) the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 7.5-5; or
- (c) the Judicial Review Committee failed to sustain an action or recommendation from the Medical Executive Committee that, based on the evidence in the hearing record was reasonable and warranted.

7.5-3 APPEAL BOARD

The Board of Directors may sit as the appeal board, or it may delegate that function to an appeal board which shall be composed of not less than three (3) individuals designated by the Board of Directors. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. The appeal board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal. The attorney firm selected by the Board of Directors shall be neither the attorney firm that represented either party at the hearing before the Judicial Review Committee nor the attorney who assisted the hearing panel or served as hearing officer.

7.5-4 TIME, PLACE AND NOTICE

The appeal board shall, within thirty (30) days after receipt of request for appellate review, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The appellate review shall commence within sixty (60) days from the date of such request for appellate review, provided however, that when a request for appellate review concerns a practitioner who is under suspension which is then in effect, the appellate review should commence within forty-five (45) days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the appeal board for good cause.

7.5-5 APPEAL PROCEDURE

The proceeding by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the Judicial Review Committee, provided that the appeal board may accept additional oral or

written evidence, subject to a foundational showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the judicial review hearing; or the appeal board may remand the matter to the Judicial Review Committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, to present a written statement in support of that party's position on appeal, and to personally appear and make oral argument. The appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The appeal board shall present to the Board of Directors its written recommendations as to whether the Board of Directors should affirm, modify, or reverse the Judicial Review Committee decision consistent with the standard set forth in Section 7.5-6, or remand the matter to the Judicial Review Committee for further review and decision.

7.5-6 DECISION

- (a) Except as provided in Section 7.5-6(b), within thirty (30) days after the conclusion of the appellate review proceedings, the Board of Directors shall render a final decision. The Board of Directors may affirm, modify, reverse the decision or remand the matter for further review by the Judicial Review Committee or any other body designated by the Board of Directors for reconsideration stating the purpose for the referral. The Board of Directors shall give great weight to the Judicial Review Committee findings and shall not act arbitrarily or capriciously. The Board of Directors may, however, exercise its independent judgment in determining whether a practitioner was afforded a fair hearing, whether the decision was reasonable and warranted, and whether any bylaw or policy relied upon by the Judicial Review Committee is unreasonable and unwarranted. The decision shall be in writing, shall specify the reasons for the action taken, and shall provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal (if any), and the decision reached, if such findings and conclusions differ from those of the Judicial Review Committee. If the Board of Directors determines that the practitioner was not afforded a fair hearing in compliance with the Bylaws, the Board of Directors shall remand the matter.
- (b) If the matter is remanded to the Judicial Review Committee or other body designated by the Board of Directors for further review and recommendation, the committee shall promptly conduct its review and make its recommendations to the Board of Directors. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree or for good cause as jointly determined by the Chair of the Board of Directors and the Judicial Review Committee.
- (c) The appeal board's decision shall constitute the final decision of the District. Any recommendation affirmed by the appeal board shall become effective immediately. The decision reached shall be forwarded to the Chief of Staff, the Medical Executive and Credentials Committees, the subject of the hearing, the Chief Medical Officer and the Administrator.

7.5-7 RIGHT TO ONE HEARING

Except in circumstances where a new hearing is ordered by the Board of Directors or a court because of procedural irregularities or otherwise for reasons not the fault of the practitioner, no practitioner shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.

7.6 EXCEPTION TO HEARING RIGHTS

7.6-1 AUTOMATIC ACTION BASED UPON ACTIONS TAKEN BY ANOTHER PEER REVIEW BODY

(a) The Medical Executive Committee shall be empowered to:

- (1) use as a basis for disqualification from membership and/or privileges, or
- (2) automatically impose

any adverse action that has been taken within the preceding thirty-six (36) months by another peer review body (as that term is used in the federal or California laws) after that action is considered final and the action was taken in conformance with California Business & Professions Code section 809 et seq. For purposes of this Section, an action shall be considered final when the practitioner has completed the hearing, appeal and judicial proceedings related to the action.

(b) The practitioner shall not be entitled to any hearing or appeal unless the Medical Executive Committee takes an action that is more restrictive than the final action taken by the original peer review body. Any hearing and appeal that is requested by the practitioner shall not address the merits of the action taken by the original peer review body, which were already reviewed at the original peer review body's hearing, and shall be limited to only the question of whether the automatic action is more restrictive than the original peer review body's action.

(c) Nothing in this Section shall preclude the Medical Staff or Board of Directors from taking a more restrictive action than another peer review body based upon the same facts or circumstances.

ARTICLE VIII: ADVANCED PRACTICE PROVIDERS

8.1 QUALIFICATIONS OF ADVANCED PRACTICE PROVIDERS

Advanced Practice Providers (APPs) are non-physician practitioners who are eligible to apply for privileges at Northern Inyo Healthcare District. APPs are not eligible for Medical Staff membership as described in California state law. They may be granted practice privileges if they hold a license, certificate or other credentials in a category of APPs that the Board of Directors (after securing Medical Executive Committee recommendation) has identified as eligible to apply for practice privileges, and only if the APPs are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws as demonstrated by the Medical Staff ongoing and focused professional practice evaluation process.

8.2 CATEGORIES

The Board of Directors may determine, based upon recommendation of the Medical Executive Committee and such other information as it has before it, those categories of APPs that shall be eligible to exercise privileges at Northern Inyo Healthcare District. Such APPs shall be subject to the supervision requirements developed and approved by the Interdisciplinary Practice Committee, the Medical Executive Committee, and the Board of Directors.

8.3 PRIVILEGES

- (a) APPs may exercise only those setting-specific privileges granted to them by the Board of Directors. The range of privileges for which each APP may apply, and any special limitations or conditions to the exercise of such privileges, shall be based on recommendations of the Interdisciplinary Practice Committee, subject to approval by the Credentials Committee, the Medical Executive Committee and the Board of Directors.
- (b) An APP must apply and qualify for practice privileges. Applications for initial granting of practice privileges and biennial renewal thereof shall be submitted and processed in a similar manner to that provided for Medical Staff members, unless otherwise specified in Medical Staff policies.
- (c) Each APP shall be subject to terms and conditions similar to those specified for Medical Staff members as they may logically be applied to APPs and appropriately tailored to the particular APP.

8.4 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

The prerogatives which may be extended to an APP shall be defined in Medical Staff and/or District policies. Such prerogatives may include:

- (a) Provision of specified patient care services, which services may be provided independently or under the supervision or direction of a Medical Staff member and consistent with the practice privileges granted to the APP and within the scope of the APP's licensure or certification.
- (b) Participation in the open session of general meetings of the Medical Staff in a non-voting role.
- (c) Being a voting participant at departmental committees appropriate to their specialty, which vote shall be limited to the following:
 - (1) Departmental policies, procedures, or other matters specific to the APP's line of practice; and
 - (2) Election of Department Chief.
- (d) Attendance at District and Medical Staff education programs.

Additionally, each APP shall:

- (a) Meet those responsibilities required by applicable policies and as specified in the Bylaws, Section 2.5, and as they may be logically applied to reflect the scope of practice of the APP.
- (b) Retain appropriate responsibility within the APPs area of professional competence for the care and supervision of each patient in the District for whom the APP is providing services.
- (c) Participate in peer review of other APPs as appropriate, participate in quality improvement and discharge such other functions as may be required from time to time.

8.5 PROCEDURAL RIGHTS OF ADVANCED PRACTICE PROVIDERS

8.5-1 GRIEVANCE RIGHTS AFTER ADVERSE ACTIONS

Except as otherwise provided in this Section with respect to automatic termination or other matters, an APP shall have the right to utilize the grievance hearing process set forth in this Section in order to challenge any action that, if taken against a Medical Staff member, would be an adverse action constituting grounds for a procedural rights hearing pursuant to these Bylaws. However, nothing contained in these Bylaws shall be interpreted to entitle an APP to procedural rights, including, but not limited to, a procedural rights hearing or appellate review to which a Medical Staff member may be entitled.

An APP may challenge such adverse action by filing a written grievance with the Medical Executive Committee no later than fifteen (15) days after such action. Upon receipt of such a grievance, the Medical Executive Committee or its designee shall conduct an investigation that shall afford the APP an opportunity for an interview concerning the grievance. Any such interview shall not constitute a “hearing” pursuant to the Bylaws and shall not be conducted according to the procedural rules applicable to such hearings as set forth in Article VII. Before the interview, the APP shall be informed of the general nature and circumstances giving rise to the action, and the APP may present information relevant thereto at the interview. A record of the interview shall be made. The Medical Executive Committee or its designee shall make a decision and recommendation for final action based on the interview and all other information available to it, and shall submit a written report of its recommendation, decision, and statement of basis for it to the Board of Directors. After receipt of the Medical Executive Committee report, the Board of Directors shall take final action on the matter.

8.5-2 EMPLOYMENT BY THE DISTRICT

If the APP is an employee of Northern Inyo Healthcare District, disciplinary actions related to the terms and conditions of employment of the APP shall be governed by applicable human resources policies.

8.5-3 AUTOMATIC TERMINATION

- (a) Notwithstanding the provisions of Section 8.5-1, an APP’s privileges shall automatically terminate without review if the APP’s certification or license expires, is revoked, or is suspended.
- (b) Notwithstanding the provisions of Section 8.5-1, an APP’s privileges may be subject to termination following review by the Interdisciplinary Practice Committee and Medical Executive Committee if no appropriate supervising practitioner is available because:
 - (1) The Medical Staff membership of the supervising practitioner is terminated, whether such termination is voluntary or involuntary and no other member is able or willing to function as the supervising practitioner; or

- (2) The supervising practitioner no longer agrees to act as the supervising practitioner for any reason, or the relationship between the APP and the supervising practitioner is otherwise terminated, regardless of the reason thereof and no other member is able or willing to function as the supervising practitioner.

(c) Additionally, APPs are subject to the automatic action provisions of Section 6.4 of these Bylaws.

8.5-4 REVIEW OF CATEGORY DECISIONS

The grievance rights afforded by this Section shall not apply to any decision regarding whether a category of APP shall or shall not be eligible for practice privileges and the terms, prerogatives, or conditions of such decision. Those questions shall be submitted for consideration to the Board of Directors, which has the discretion to decline to review the request or to review it using any procedure the Board of Directors deems appropriate.

ARTICLE IX: OFFICERS

9.1 OFFICERS OF THE MEDICAL STAFF

9.1-1 IDENTIFICATION

The officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff, Immediate Past Chief of Staff, and member(s)-at-large. In addition, the Medical Staff's Department Chiefs shall be deemed Medical Staff Officers within the meaning of California law.

9.1-2 QUALIFICATIONS

Officers must be members of the active Medical Staff at the time of their nomination and election, and must remain members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

The Chief Medical Officer will not be eligible to hold Medical Staff Office during employment by the District. Should a Medical Staff Officer accept a position as Chief Medical Officer they will resign from their Medical Staff position and a replacement shall be determined per the process outlined in these Bylaws. The Chief Medical Officer will retain voting privileges to which they are eligible to participate based on their rights as an active Medical Staff member.

Additionally, if possible, the Chief of Staff must have previously served on the Medical Executive Committee in some capacity for at least one term.

9.1-3 NOMINATIONS

- (a) Elections for Chief of Staff shall be every two years. Elections for member(s)-at-large shall be every year.
- (b) The Medical Executive Committee shall nominate one or more nominees for the office of Chief of Staff and may nominate one or more nominees for member-at-large to be filled at the time of elections. The Medical Executive Committee shall give notice of the nominations to members eligible to vote on the officers no later than thirty (30) days prior to the election.
- (c) Nominations may also be made by any member entitled to vote by submitting a written nomination to the Medical Staff Office. A member may also nominate him- or herself, provided that he or she qualifies for such office.
- (d) All nominees for election shall disclose in writing to the Medical Staff those current or impending personal, professional, or financial affiliations or relationships of which they are reasonably aware, including contractual, employment or other relationships with the District, which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

9.1-4 ELECTIONS

The Chief of Staff and member(s)-at-large shall be elected by written ballot sent to eligible members prior to the end of the Medical Staff year during which an election is held. Whenever feasible, the election shall be held three (3) to six (6) months prior to the end of the Medical Staff year so as to give the newly elected officer the opportunity to begin transitioning into the role. Voting shall be by written ballot submitted to the Medical Staff Office or via electronic vote.

A nominee for Chief of Staff shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the Medical Executive Committee shall decide the election by written ballot at its next meeting or a special meeting called for that purpose.

In the election for member-at-large where there are two or more nominees, the two nominees receiving the highest numbers of votes shall be elected to each serve in the role of member-at-large. If there are not two or more nominees on the ballot, only one position of member-at-large need be filled.

9.1-5 TERM OF ELECTED OFFICE

The Chief of Staff shall serve a two (2) year term, commencing on the first day of the Medical Staff year following the election. The Chief of Staff shall be eligible to serve consecutive terms.

The Vice Chief of Staff, Immediate Past Chief of Staff, and member(s)-at-large shall serve a one (1) year term. The Vice Chief of Staff and member(s)-at-large shall be eligible to serve consecutive terms.

Each officer shall serve until the end of that officer's term, unless that officer resigns or is removed from office.

9.1-6 RECALL OF OFFICERS

Any Medical Staff Officer may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude. Recall of a Medical Staff Officer may be initiated by the Medical Executive Committee or by a petition signed by at least one-third of the members of the active Medical Staff presented to the Medical Executive Committee or Chief of Staff. Recall shall require a majority vote of the Medical Executive Committee. A special meeting may be called for this purpose.

At least ten (10) days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the Medical Executive Committee prior to a vote on removal. This provision does not include actions such as summary suspension where such timeline may not be feasible.

9.1-7 VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the Medical Staff. Vacancies shall be filled by appointment by the Chief of Staff with consultation with the Medical Executive Committee until the next regular election, except for the member-at-large, which may remain vacant.

9.2 DUTIES OF OFFICERS

9.2-1 CHIEF OF STAFF

The Chief of Staff shall serve as the chief officer of the Medical Staff. With the assistance of the Medical Executive Committee where appropriate, the duties required of the Chief of Staff (or designee, as allowed by the Bylaws) shall include, but not be limited to:

- (a) enforcing the Medical Staff Bylaws and policies, implementing sanctions where indicated in consultation with the Medical Executive Committee, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;
- (b) calling, presiding at, and being responsible for the agenda of all general meetings of the Medical Staff;

- (c) serving as Chair of the Medical Executive Committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;
- (d) in the interim between Medical Executive Committee meetings, performing those responsibilities of the committee that, in the Chief of Staff's opinion, must be performed prior to the next regular or special meeting of the committee;
- (e) serving as an ex-officio member of all other Medical Staff committees without vote, unless Chief of Staff membership in a particular committee is required by these Bylaws;
- (f) interacting with the Administrator, Chief Medical Officer and Board of Directors in all matters of mutual concern within the District;
- (g) representing the views and policies of the Medical Staff to the Board of Directors, the Administrator or designee, and Chairing the Joint Conference Committee as indicated in these Bylaws;
- (h) regularly reporting to the Board of Directors on the performance of Medical Staff functions and communicating to the Medical Staff any concerns expressed by the District Board;
- (i) being a spokesperson for the Medical Staff in external professional and public relations;
- (j) serving on liaison committees with the Board of Directors and administration, as well as outside licensing or accreditation agencies;
- (k) performing such other functions as may be assigned to the Chief of Staff by the Bylaws, the Medical Staff, or the Medical Executive Committee.

9.2-2 VICE CHIEF OF STAFF

The Vice Chief of Staff shall serve a one (1) year term and is selected from among the current members serving on the Medical Executive Committee. The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff and shall perform such other duties as may be assigned.

9.2-3 IMMEDIATE PAST CHIEF OF STAFF

The Immediate Past Chief of Staff will remain a member of the Medical Executive Committee for one (1) year, and shall attend at least the first three (3) consecutive months of their term to assure a smooth transition with the change in leadership and longer as deemed necessary. The Immediate Past Chief of Staff shall perform such other duties as may be assigned.

9.2-4 MEMBER-AT-LARGE

There may be one or two officers with the title member-at-large. The member(s)-at-large shall be members of the Medical Executive Committee and shall perform duties as may be assigned.

ARTICLE X: CLINICAL DEPARTMENTS

10.1 ORGANIZATION OF CLINICAL DEPARTMENTS

The active Medical Staff shall be organized into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a Chief selected and entrusted with the authority, duties, and responsibilities specified in this Article. When appropriate, or at the recommendation of the departmental committee, the Medical Executive Committee may approve the creation, elimination, modification, or combination of departments.

Department committees, as described in Article XI, may represent a single clinical department or a combination of clinical departments as appropriate.

Additional medical or surgical specialties not currently listed as a department will be assigned to an existing department through the credentialing and privileging process.

10.2 DEPARTMENTS

The clinical departments under these Bylaws are:

- (a) Anesthesia
- (b) Emergency Medicine
- (c) Surgery (including Pathology)
- (d) Inpatient Medicine
- (e) Obstetrics & Gynecology
- (f) Orthopedic Surgery (including Podiatry)
- (g) Outpatient Medicine
- (h) Pediatrics
- (i) Radiology

10.3 ASSIGNMENT TO DEPARTMENTS

Each privileged practitioner shall be assigned membership based on specialty or board certification in at least one department, but may also be granted membership and/or clinical privileges in other departments consistent with practice privileges granted.

10.4 FUNCTIONS OF DEPARTMENTS

The general functions of each department shall include:

- (a) Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department, as per the Medical Staff's policy on ongoing and focused professional practice evaluation.
- (b) Recommending to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the department.

- (c) Evaluating and making appropriate recommendations to the Credentials Committee and the Medical Executive Committee regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that department.
- (d) Reviewing and evaluating departmental adherence to: (1) Medical Staff and District policies and procedures, (2) sound principles of clinical practice, and (3) quality improvement.
- (e) Coordinating with nursing and ancillary staff in regards to patient care provided by the department's members with nursing and ancillary patient care services.
- (f) Reporting to the departmental committee concerning: (1) the activities of the department, and (2) recommendations for maintaining and improving the quality of care provided in the department and the District.
- (g) Meeting regularly for the purpose of considering patient care review findings and the results of the department's other review and evaluation activities, as well as reports on other department and staff functions.
- (h) Taking appropriate action when problems in patient care and clinical performance or opportunities to improve care are identified.
- (i) Formulating departmental policies/procedures as reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Executive Committee.

10.5 DEPARTMENT CHIEFS

10.5-1 QUALIFICATIONS

Each department shall have a Chief who shall be a member of the active staff and shall be qualified by licensure, training, experience and demonstrated ability in at least one of the clinical areas covered by the department. If required by applicable California regulations or other law, the Department Chief must be certified by an appropriate specialty board or eligible for certification by an appropriate specialty board. Otherwise, the Department Chief shall possess comparable competence as affirmatively established through the peer review process.

10.5-2 SELECTION

The Department Chief shall be elected by the voting members of their department. In the event of a tie vote, the Chief will be appointed by vote of the Medical Executive Committee. Departments with a single member will automatically have the single member designated as Chief. Vacancies due to any reason shall be filled for the unexpired term through special election by the respective department with such mechanisms as that department may adopt.

10.5-3 TERM OF OFFICE

Each Department Chief shall serve a one (1) year term which coincides with the Medical Staff year or until his or her successor is chosen, unless he or she shall sooner resign, be removed from office, or lose his or her Medical Staff membership or clinical privileges in that department. Department Chiefs shall be eligible to serve consecutive terms.

10.5-4 REMOVAL

Removal of Department Chiefs from office may occur for cause by a two-thirds vote of the department members. The Medical Executive Committee may remove Department Chiefs in the course of a corrective action proceeding as indicated.

10.5-5 DUTIES

Each Chief shall have the following authority, duties and responsibilities, and shall otherwise perform such duties as may be assigned:

- (a) oversee the quality of patient care, professional performance and behaviors rendered by practitioners with clinical privileges in the department and designate proctors as necessary;
- (b) assign a member of the Medical Staff to assume responsibility for duties and/or the care of another member's patients in the event the member is unable to fulfill their obligations due to termination of privileges, illness, or similar extenuating circumstances;
- (c) enforce the Medical Staff Bylaws and Medical Staff and District policies within the department;
- (d) implement within the department appropriate actions taken by the Medical Executive Committee;
- (e) coordinate with District administration, department Medical Director (if any), and nursing services in matters relevant to the department;
- (f) perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff or the Medical Executive Committee.

ARTICLE XI: COMMITTEES

11.1 DESIGNATION

The Medical Executive Committee and the other committees described in these Bylaws shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee or the Chief of Staff to perform specified tasks. Any committee that is carrying out all or any portion of a function or activity required by these Bylaws is deemed a duly-appointed and authorized committee of the Medical Staff.

11.2 GENERAL PROVISIONS

11.2-1 APPOINTMENT OF COMMITTEE MEMBERS AND CHAIRS

The chair and members of committees shall be designated as per the Bylaws. If not specified in the Bylaws, the chair and members of committees shall be appointed by and may be removed by the Chief of Staff, subject to consultation with the Medical Executive Committee. Medical staff committees shall be responsible to the Medical Executive Committee. Each committee chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

The Administrator, or his or her designee, shall appoint any non-Medical Staff committee members who are not otherwise designated by title in the provision or resolution creating the committee.

The removal of any committee member who is automatically assigned to a committee because he or she is a general officer or other official shall be governed by the provisions pertaining to removal of such officer or official.

11.2-2 COMMITTEE COMPOSITION

Except as otherwise provided in the Bylaws, committees established to perform Medical Staff functions required by these Bylaws may include any category of: Medical Staff members; Advanced Practice Providers; representatives from District services such as administration, nursing services, or medical records; representatives of the community; and persons with special expertise, depending upon the functions to be discharged. Each active Medical Staff member and Advanced Practice Provider who serves on a committee participates with vote unless the statement of committee composition provides for designation of the position as non-voting.

11.2-3 REPRESENTATION ON DISTRICT COMMITTEES AND PARTICIPATION IN DELIBERATIONS

The Medical Staff may discharge its duties relating to medical records, utilization review, infection control, pharmacy and therapeutics, accreditation, licensure, certification, disaster planning, facility and services planning, financial management, and physical plant safety by providing Medical Staff representation on District committees established to perform such functions. The Medical Executive Committee or Chief of Staff will be responsible for providing-appointing a Medical Staff or APP representative on District committees when requested by the Board or administration. Reports of activities and recommendations relating to infection control, medical records, utilization review, and pharmacy and therapeutics shall be made to the Medical Executive Committee at least quarterly.

11.2-4 EX-OFFICIO MEMBERS

The Chief of Staff and the Administrator or designee are ex-officio members of all standing and special committees of the Medical Staff. They and all other persons designated to serve as ex-officio committee members shall serve without vote unless provided otherwise in the provision or resolution creating the committee.

11.2-5 ACTION THROUGH SUBCOMMITTEES

Any Medical Staff standing committee may establish subcommittees to assist in carrying out its duties, in addition to any such subcommittees established by the Medical Executive Committee or expressly designated in the Bylaws. A subcommittee shall be composed of one or more voting members of the standing committee. The Medical Executive Committee shall be informed when a subcommittee is established. The committee Chair may also appoint individuals to serve as non-voting subcommittee members, after consulting with, and subject to the approval of, the Chief of Staff regarding Medical Staff members, and the Administrator or designee regarding District personnel. An ad hoc committee is not considered a subcommittee.

11.2-6 TERM OF COMMITTEE MEMBERS

The term of committee members shall be as designated in the Bylaws. If not specified, a committee member shall be appointed for a term of one year, subject to unlimited renewal, and shall serve until the end of this period and until his or her successor is appointed, unless he or she shall sooner resign or be removed from the committee.

11.2-7 COMMITTEE VACANCIES

Unless otherwise specified, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

11.2-8 LIMITATION OF ATTENDANCE AT COMMITTEE MEETINGS

Unless otherwise specified in the Bylaws, any privileged practitioner who is in good standing may be permitted to attend any portion of a Medical Staff committee's meeting dealing with a matter of importance to that practitioner even though the practitioner is not a member of the committee. However, the committee Chair or the Chief of Staff shall have the discretion to deny entry to the meeting to such practitioner, or to request any nonmember to leave the meeting. Any such nonmember who attends shall abide by all Bylaws applicable to that committee.

In addition, during any portion of a committee meeting when the committee is in closed session or conducting peer review and chart review functions with respect to specific Medical Staff members, applicants, or other practitioners or Advanced Practice Providers, attendance at the committee's meeting shall be restricted to (a) privileged practitioners who are members of the committee through assignment or election by the Medical Staff, and (b) any Medical Staff member or other person whom the committee has invited or requested to attend to assist in the functions (but only for the portion of the meeting designated by the committee or the committee Chair).

The committee Chair, after consulting with the Chief of Staff and Administrator, may call on outside consultants or other special advisors to assist the committee in fulfilling its duties and allow such special advisors to attend committee meetings related to the assistance they are providing, but such advisors shall not be deemed members of the committee.

Any nonmember who attends a committee meeting shall be deemed to have agreed, by his or her presence at the meeting, to maintain the confidentiality of and to refrain from any unauthorized disclosure to other persons of the committee's records, deliberations, and proceedings.

11.2-9 ACCOUNTABILITY

All Medical Staff committees shall be accountable to the Medical Executive Committee.

11.3 MEDICAL EXECUTIVE COMMITTEE

11.3-1 COMPOSITION

The Medical Executive Committee shall be composed of the Chief of Staff, Vice Chief of Staff, Immediate Past Chief of Staff, Department Committee Chairs, Chief of Anesthesia, Chief of Surgery, Chief of Orthopedics, and up to two members-at-large, if elected. The Chief of Staff shall chair and preside over the Medical Executive Committee. The Administrator or designee and the Chief Nursing Officer shall be a non-voting ex-officio members.

11.3-2 DUTIES

With the assistance of the Chief of Staff and/or the use of ad hoc committees as appropriate, the Medical Executive Committee shall:

- (a) represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;
- (b) ensure the Medical Staff fulfills its responsibilities to the District Board as per the District Bylaws;
- (c) monitor, evaluate, and supervise the performance of all Medical Staff functions, including conducting an annual review of Medical Staff policies;
- (d) review, evaluate, or take other appropriate action for matters related to the competence and other qualifications of privileged practitioners or practitioners applying for privileges;
- (e) take reasonable steps to promote ethical conduct and competent clinical performance on the part of all privileged practitioners and when indicated, initiate and/or pursue disciplinary or corrective actions affecting privileged practitioners, as provided in the Bylaws;
- (f) ensure Medical Staff's knowledge of and compliance with the Medical Staff Bylaws and policies; the District's Bylaws, rules, and policies; state and federal laws and regulations; and other accreditation requirements;
- (g) oversee the development of Medical Staff policies, approve (or disapprove) all such policies, and oversee the dissemination and implementation of all such policies following their approval by the Medical Staff;
- (h) implement, as they relate to the Medical Staff, the approved policies, procedures, standards, and rules of the District, including, without limitation, the Compliance program (which program relates to Medicare and Medi-Cal fraud and abuse matters); the District confidentiality policies and procedures related to compliance with applicable law, including but not limited to the federal Health Insurance Portability and Accountability Act ("HIPAA") and the California Medical Information Act; and the District medical error reporting program, including without limitation, applicable disclosure and reporting protocols.
- (i) provide liaison between the Medical Staff, the Administrator and the District Board by regularly reporting to the District Board and to the Medical Staff;
- (j) make recommendations to the District Board regarding Medical Staff structure, membership and privileges requirements, application, disciplinary, and hearing procedures, peer review and quality

assessment and improvement activities, and other aspects of Medical Staff affairs addressed in the Medical Staff Bylaws;

- (k) make recommendations to administration in the selection of and assignment of responsibilities to department Medical Directors, the Chief Medical Officer, or other practitioners contracted by the District to provide administrative services;
- (l) review and make recommendations to the Chief Medical Officer regarding quality of care issues related to specified clinical services contract arrangements for professional medical services;
- (m) participate and provide information when requested in District proceedings involved with making specified clinical services contracting decisions;
- (n) in collaboration with the District, oversee the development and implementation of a District-wide quality improvement plan and recommend revisions as needed;
- (o) review quality improvement reports from Department Chiefs, committees, and other Medical Staff patient care review activities;
- (p) establish, as needed, such ad hoc committees that will fulfill particular functions for a limited time and will report directly to the Medical Executive Committee;
- (q) appoint committee members for all standing committees, all special Medical Staff, liaison, or multi-disciplinary committees, and designating the Chairs of these committees, except where otherwise provided by these Bylaws; and
- (r) recommend the amount of annual dues for each Medical Staff membership category, subject to Medical Staff approval, and recommend the manner of expenditure of dues funds, subject to the committee's acknowledgment that such expenditures must be consistent with applicable law regarding such expenditures.

11.3-3 MEETINGS

The Medical Executive Committee should be scheduled to meet on a monthly basis and shall meet at least ten (10) times during the Medical Staff year.

11.4 BYLAWS COMMITTEE

11.4-1 COMPOSITION

The Bylaws Committee shall be composed of at least three (3) active staff members.

11.4-2 DUTIES

The Bylaws Committee shall make reasonable efforts to assure that the Medical Staff Bylaws and policies adequately and accurately reflect the current structure and practices of the Medical Staff and comply with applicable legal requirements by:

- (a) conducting an annual review of the Bylaws;
- (b) developing and submitting proposals for Bylaws changes to the Medical Executive Committee and to the Medical Staff in accordance with Bylaws procedures;

- (c) receiving, evaluating, and making recommendations with respect to Bylaws or policies proposals made by the Medical Executive Committee, Department Chiefs, member petition or other sources; and
- (d) engaging in such other activities as reasonably appropriate for fulfilling these and other functions as specified in the Bylaws or policies.

11.4-3 MEETINGS AND REPORTS

The Bylaws Committee will meet at least annually and otherwise as requested by the Bylaws Committee Chair or Chief of Staff. The committee shall report its activities and recommendations at least annually to the Medical Executive Committee.

11.5 CREDENTIALS COMMITTEE

11.5-1 COMPOSITION

The Credentials Committee shall be composed of at least five (5) active staff members, selected on a basis that will ensure insofar as feasible, representation of the clinical departments and the major clinical specialties which are routinely practiced by privileged practitioners at Northern Inyo Healthcare District.

11.5-2 DUTIES

The Credentials Committee shall evaluate and make recommendations with respect to the qualifications of all applicants for Medical Staff appointment, reappointment, privileges, and changes in staff categories, and fulfill other functions as specified in the Bylaws or policies.

11.5-3 MEETINGS AND REPORTS

The Credentials Committee shall meet at least quarterly, or as often as necessary as determined and called by the committee Chair, the Chief of Staff, or the Medical Staff Office. The committee shall report its activities and recommendations with respect to applicants as specified in the Bylaws and shall otherwise report the status of pending applications and its activities to the Medical Executive Committee.

~~11.6 INFECTION CONTROL COMMITTEE~~

~~11.6-1 COMPOSITION~~

~~The infection control committee shall be composed of at least two (2) privileged practitioners, at least one (1) of which shall be an active staff member, and the infection prevention nurse (with vote). A quorum shall consist of one (1) privileged practitioner and the infection prevention nurse.~~

~~Ex-officio members serving without vote shall include the Administrator (or the Administrator's designee), and a representative from the clinical laboratory (bacteriology). In addition, representatives from areas such as, but not limited to, the employee health, dietary, respiratory therapy, and environmental service departments may be invited to attend and participate in discussion without vote. The Chair of the infection control committee shall be required to complete the necessary infection control training as mandated per state regulations.~~

~~11.6-2 DUTIES~~

~~The duties of the infection control committee shall include assisting the District in:~~

- ~~(a) developing a hospital-wide infection control program and maintaining surveillance over the program;~~

- ~~(b) developing a system for reporting, identifying and analyzing the incidence and cause of healthcare-associated infections, including assignment of responsibility for the ongoing collection and analytic review of such data;~~
- ~~(c) monitoring implementation of corrective actions for healthcare-associated infections, and making recommendations to eliminate future such infections;~~
- ~~(d) developing and implementing a preventative and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;~~
- ~~(e) developing written policies defining special indications for isolation requirements;~~
- ~~(f) coordinating actions on findings from the Medical Staff's review of the clinical use of antibiotics;~~
- ~~(g) taking such actions as reasonably necessary to assure infection control compliance with regulatory agencies and with established guidelines such as those of the Center for Disease Control and APIC (Association for Professionals in Infection Control and Epidemiology); and~~
- ~~(h) reviewing sensitivities of organisms specific to the facility.~~

~~11.6.3 MEETINGS~~

~~The infection control committee shall meet at least quarterly. The committee, or a representative of the committee, shall provide to the Medical Executive Committee regular reports of the committee's activities.~~

~~11.711.6~~ INTERDISCIPLINARY PRACTICE COMMITTEE

~~11.7-111.6-1~~ COMPOSITION

The Interdisciplinary Practice Committee (IDPC) shall be composed of:

- (a) an equal number of Medical Staff members who are physicians and nursing staff who are registered nurses;
- (b) the lead Advanced Practice Provider;
- (c) the Chief Nursing Officer; and
- (d) the Administrator (or the Administrator's designee, who may not be a registered nurse or a physician Medical Staff member).

The Medical Executive Committee shall appoint the physician members and designate one of them as the Chairperson. The Chief Nursing Officer shall appoint the nursing staff members. In addition, representatives in the categories of Advanced Practice Providers granted privileges in the District may serve as consultants on an as-needed basis, and shall participate, when requested and feasible, in the committee proceedings when a member of the same APP category is applying for privileges.

~~11.7-211.6-2~~ DUTIES

The IDPC functions to establish, implement, monitor, and evaluate policies and procedures for interdisciplinary medical practice pursuant to Title 22, California Code of Regulations, Sections 70706 and 70706.2, other applicable law, and the Bylaws. IDPC duties shall include, but not necessarily be limited to, the standardized procedures and credentialing duties as set forth below in this Section.

(a) STANDARDIZED PROCEDURE DUTIES:

- (1) The IDPC shall develop and review standardized procedures that apply to nurses or APPs, identify functions that are appropriate for standardized procedures, initiate such procedures, and review and approve standardized procedures in accordance with applicable licensure regulations, such as Title 22, California Code of Regulations, Sections 70706 and 70706.2, other applicable law, and the Bylaws.
- (2) Request for development of standardized procedures may be initiated by the Administrator, the Chief Medical Officer, the Chief Nursing Officer, the Medical Executive Committee, the Chief of Staff, the appropriate Department Chiefs, the affected registered nurses or APPs, or supervising practitioners.
- (3) Prior to approval of new or amended standardized procedures, the IDPC shall obtain consultation and recommendations from the Department Chief(s), other appropriate Medical Staff members, and non-Medical Staff members who practice in the clinical field or medical or nursing specialties under review as subject of the proposed standardized procedures.
- (4) Standardized procedures shall be reviewed and approved by the IDPC, the Medical Executive Committee, the Administrator, and the Board of Directors in order to become effective.
- (5) The IDPC may approve standardized procedures only by affirmative vote of the following IDPC members: the Administrator (or the Administrator's designee), a majority of the physician members, and a majority of the registered nurse members (including the Chief Nursing Officer).
- (6) The IDPC is responsible for assuring that standardized procedures are a collaborative effort among Administrators and health professionals, including physicians and nurses. Each standardized procedure shall:
 - i. Be in writing and show the date or dates of each required approval, including approval by the IDPC;
 - ii. Specify which standardized procedure functions which registered nurses are authorize to perform and under what circumstances;
 - iii. State any specific requirements which are to be followed by registered nurses in performing all or part of the functions covered by the particular standardized procedure;
 - iv. Specify any experience, training, and/or special education requirements for performance of the standardized procedure functions;
 - v. Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform the standardized procedure functions;
 - vi. Provide for a method of maintaining a written record of those persons authorized to perform the standardized procedure functions;
 - vii. Specify the nature and scope of review and/or supervision required for performance of the standardized procedure functions. For example, if the function is to be performed only under the immediate supervision of a physician, that limitation

must be clearly stated. If physician supervision is not required, that fact should be clearly stated;

- viii. Set forth any specialized circumstances under which the registered nurse is to communicate immediately with a patient's physician concerning the patient's condition;
- ix. State the limitations on settings or departments within the facility where the standardized procedure functions may be performed;
- x. Specify any special requirements for procedures relating to patient recordkeeping; and
- xi. Provide for a method of periodic review of the standardized procedure.

(b) CREDENTIALING ADVANCED PRACTICE PROVIDERS DUTIES:

- (1) Upon request by the Medical Executive Committee or the Board of Directors, or at its own initiative, the IDPC shall make recommendations regarding APP category eligibility, delineation of APP practice privileges, supervision requirements, and other such matters related to APP practice at the District.
- (2) The IDPC shall review and evaluate APP applications and requests for privileges and forward its written report and recommendations to the appropriate Department Chief or Credentials Committee.
- (3) The IDPC shall serve as liaison between APPs and the Medical Staff.

~~11.7~~ 11.6-3 MEETINGS

The IDPC shall meet as often as needed, but at least annually. The committee shall report its activities and recommendations with respect to applicants as specified in the Bylaws to the Credentials Committee.

~~11.8~~ 11.7 JOINT CONFERENCE COMMITTEE

~~11.8~~ 11.7-1 COMPOSITION

The Joint Conference Committee is an ad hoc committee composed of two (2) members of the Board of Directors and two (2) members of the Medical Executive Committee, one (1) of which shall be the Chief of Staff, and the other which shall be appointed by the Medical Executive Committee. The Administrator, or designee, shall be a non-voting, ex-officio member. The Chair of the committee should alternate yearly between the Board of Directors and the Medical Staff; odd-numbered years will be the Board of Directors, and even-numbered years will be the Medical Staff.

~~11.8~~ 11.7-2 DUTIES

The function of the Joint Conference Committee is to serve as a liaison between members of the Board of Directors, the District administration, and the Medical Staff on an ad hoc basis. The Joint Conference Committee shall act in an advisory function and provide a forum for:

- (a) the maintenance of effective communications to keep the Board, Medical Staff, and the Administrator cognizant of any pertinent actions taken or contemplated;
- (b) the planning for growth and development of the District and the Medical Staff;

- (c) the discussion of matters of District and Medical Staff policy, practice, and planning not related to peer review; and
- (d) the interaction between the Board of Directors and the Medical Staff on such matters as may be referred by the Medical Executive Committee or the Board of Directors.

The Joint Conference Committee may also meet on an ad hoc basis to act as a deliberative body as described below for:

- (a) the resolution of conflicts or disputes between the Medical Staff and the Board of Directors or administration; and
- (b) the resolution of any dispute related to the Medical Staff's rights or self-governance or discharge of Medical Staff responsibilities.

~~11.8-3~~11.7-3 DISPUTE RESOLUTION PROCESS

All disputes between administration or the Board of Directors and the Medical Staff that have not been resolved by prior informal meetings and discussions shall be addressed to and mediated by the Joint Conference Committee.

- (a) Following written notice of a dispute needing mediation, the committee shall convene within fourteen (14) days after the next regularly scheduled District Board meeting.
- (b) The committee shall meet and confer in good faith to formulate a recommendation for mediation of the dispute.
- (c) If the committee cannot reach a consensus, the committee may appoint an outside professional mediator as a member of the committee, and the mediator shall serve as the Chair of the committee but shall have no vote. The parties shall cooperate to select the mediator from a list of candidates provided by services such as the Judicial Arbitration and Mediation Service or the American Arbitration Association. The cost of the mediator shall be covered by the District.

~~11.8-4~~11.7-4 MEETINGS AND REPORTS

The committee shall meet as needed on an ad-hoc basis as described above. The Chief of Staff, or designee, shall report the committee's activities or discussions to the Medical Executive Committee and to the Medical Staff via email or at the next regularly scheduled meetings, as appropriate for the subject matter. Minutes shall be kept during meetings as appropriate and a copy maintained in the Medical Staff Office.

~~11.9 —~~ PHARMACY AND THERAPEUTICS COMMITTEE

~~11.9-1 COMPOSITION~~

~~The pharmacy and therapeutics committee shall be composed of at least three (3) active staff members, the pharmacy director (with vote), and the Chief Nursing Officer or other nurse designated by the Chief Nursing Officer (with vote). Ex-officio members serving without vote shall include the Administrator, or the Administrator's designee, and a representative from clinical informatics. As available, the Administrator shall designate a District quality representative to this committee in a non-voting capacity.~~

~~11.9-2 DUTIES~~

~~The duties of the pharmacy and therapeutics committee shall include:~~

- ~~(a) assisting in the formulation of professional practices and policies regarding the continuing evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the hospital, including antibiotic usage;~~
- ~~(b) advising the Medical Staff and the pharmaceutical service on matters pertaining to the choice of available drugs;~~
- ~~(c) making recommendations concerning drugs to be stocked on the nursing unit floors and by other services;~~
- ~~(d) periodically reviewing and maintaining formulary or drug list for use in the hospital;~~
- ~~(e) evaluating clinical data concerning new drugs or preparations requested for use in the hospital;~~
- ~~(f) establishing standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;~~
- ~~(g) maintaining a record of all activities relating to pharmacy and therapeutics functions and submitting periodic reports and recommendations to the Medical Executive Committee concerning those activities; and~~
- ~~(h) reviewing untoward drug reactions.~~

~~11.9-3 MEETINGS~~

~~The pharmacy and therapeutics committee shall meet at least quarterly. The committee shall report a summary of its activities or findings to the Medical Executive Committee on a regular basis.~~

11.8 PEER REVIEW COMMITTEE

11.8-1 COMPOSITION

The Peer Review Committee shall be composed of at least three (3) Medical Staff members selected on a basis that will ensure insofar as feasible, representation from various specialties. Members shall not participate in the review of cases in which they have a conflict of interest.

11.8-2 DUTIES

The Peer Review Committee shall:

- (a) Promote high standards of professional practice, behavior and patient care.
- (b) Evaluate the quality, appropriateness, and efficiency of care rendered by privileged practitioners. The committee may also recommend external peer review when indicated.
- (c) Identify opportunities for improvement in clinical performance and/or professional conduct and ensure that privileged practitioners practice within accepted standards of care and in accordance with the Medical Staff's professional conduct policy.
- (d) Oversee and support the Medical Staff's Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) processes including reviewing practitioner-specific performance data and trends and identifying practitioners requiring further review, monitoring, or intervention.
- (e) Identify system issues impacting quality of care and collaborate with hospital quality programs to improve clinical outcomes.

- (f) Request specialty-specific review from non-members, as needed, to perform a thorough review, and allow the practitioner under review to provide a response. The practitioner's response shall be either in writing or in-person, as determined by the committee.
- (g) Issue recommendations to practitioners on areas of education, monitoring, or feedback.
- (h) Make recommendations to the Medical Executive Committee regarding practitioner performance concerns, including but not limited to, request for corrective action, privilege modification, limitation or revocation.

11.8-3 MEETINGS, REPORTING AND MINUTES

The Peer Review Committee shall meet as often as necessary, but at least quarterly. It shall maintain only such records of its proceedings as it deems advisable and consistent with confidentiality concerns, and all records shall be confidential and protected to the fullest extent permitted by law. The committee shall routinely report on its activities to the Medical Executive Committee.

~~11.10~~11.9 PHYSICIAN WELLNESS COMMITTEE

~~11.10-111.9-1~~ COMPOSITION

The Physician Wellness Committee shall be composed of at least three (3) Medical Staff members, one (1) of whom should be a psychiatrist whenever feasible. Insofar as feasible, members of this committee shall not actively participate on other peer review or corrective action ad hoc committees while serving on this committee.

Additionally, in order to facilitate open communication about provider wellness, meetings of the Physician Wellness Committee will be limited to the Medical Staff members of that committee and other participants will be included by invitation of the Chair of the committee only.

~~11.10-211.9-2~~ DUTIES

The committee shall:

- (a) Consider general matters related to the health and well-being of Medical Staff members and, with the approval of the Medical Executive Committee or Chief of Staff, develop educational programs or staff events for promoting well-being.
- (b) Educate staff on illness and impairment recognition issues specific to physicians.
- (c) Review, evaluate, and make recommendations as appropriate or otherwise required by the Bylaws:
 - (1) Voluntary disclosures to the committee by members or other practitioners regarding their health status;
 - (2) Health status referrals or reports from the Chief of Staff or other Medical Staff Officer or committee regarding a member; and
 - (3) Responses from applicants concerning physical or mental disabilities.
- (d) Investigate any applicant, member, or other practitioner who has or may have physical or mental disability that may affect the practitioner's capability to exercise the privileges applied for and/or held by the practitioner in a manner that meets the patient care quality standards of the District and the Medical Staff. An investigation may include any or all of the following steps:

- (1) ascertain the health status of the practitioner through committee interview;
- (2) facilitate a medical examination by an appropriate healthcare professional to evaluate whether the practitioner has a physical or mental disability or other health problem that may affect patient care;
- (3) evaluate the effects of the health status on the practitioner's capability to exercise privileges applied for or held by the practitioner, and when relevant with respect to a qualified physical or mental disability under applicable law, assess if and how reasonable accommodations can be made;
- (4) provide advice, counseling, or referrals as appropriate.

The activities of the Physician Wellness Committee shall be confidential. However, if the committee receives information that demonstrates that the health or impairment of a practitioner may pose a risk of harm to patients, self or others, that information shall be referred to the Chief of Staff or the Medical Executive Committee. This committee is not disciplinary in nature and does not preclude other review mechanisms as set forth in these Bylaws.

~~11.10-3~~11.9-3 MEETINGS, REPORTING AND MINUTES

The Physician Wellness Committee shall meet as often as necessary, but at least quarterly. It shall maintain only such records of its proceedings as it deems advisable and consistent with confidentiality concerns, and shall routinely report on its activities to the Medical Executive Committee.

~~11.11~~11.10 UTILIZATION REVIEW AND MEDICAL RECORDS COMMITTEE

~~11.11-1~~11.10-1 COMPOSITION

The Utilization Review and Medical Records Committee shall consist of at least three (3) Medical Staff members. Representatives from quality, utilization review, nursing, billing, medical records, and social services shall be invited as non-voting members.

~~11.11-2~~11.10-2 DUTIES

The Utilization Review and Medical Records Committee shall perform the following functions:

- (a) Delineate the scope of utilization review provided within the District;
- (b) Develop critical indicators to be used as screening devices in reviewing the utilization of District services;
- (c) After cases have been isolated using the critical indicators, evaluate utilization of services administered and identify areas for improvement, if necessary;
- (d) Review patient care services to ascertain if utilization of services within the standards of the District and Medical Staff are being provided in the most cost-effective manner, address overutilization, underutilization, and inefficient scheduling of care and resources;
- (e) Review diagnoses, problems, procedures and the practices of practitioners that appear to have utilization-related problems, and examine relevant quality assurance findings and interface with the practitioners as deemed necessary or appropriate;
- (f) Determine appropriate action to be taken with respect to identified utilization and other patient care problems, and report such matters to the Medical Executive Committee;

- (g) Refer problems which cannot reasonably be resolved at the committee level to the appropriate committee;
- (h) Develop, implement, and maintain such Utilization Review Plan as approved by the Medical Executive Committee and District Board; and
- (i) Comply with applicable federal and state regulations.

~~11.11-3~~11.10-3 MEETINGS

The Utilization Review and Medical Records Committee shall meet at least quarterly. The committee shall report a summary of its activities or findings to the Medical Executive Committee on a regular basis. The committee shall also give notification to the Medical Executive Committee promptly after the committee receives notice of any matter for which a practitioner is required to give notice to the Medical Staff pursuant to these Bylaws, if not already reported.

~~11.12~~11.11 DEPARTMENTAL COMMITTEES

~~11.12-1~~11.11-1 COMPOSITION

The departmental committees can represent a single clinical department or a combination of clinical departments. The departmental committees shall be composed of the practitioners assigned to the represented departments.

Members have the duty to attend all meetings of the department, unless excused for good reason by the Chair of the committee.

Additional committee members may be assigned as needed to represent all disciplines of the department at regularly scheduled meetings.

(a) Emergency Services Committee

The Emergency Services Committee shall represent all medical services provided in the emergency department. In addition, the emergency department nurse manager and the Administrator (or designee) shall be ex-officio non-voting members. Other departments may participate as needed by invitation. As available, the Administrator shall designate a District quality representative to this committee in a non-voting capacity.

(b) Inpatient Medicine Committee

The Inpatient Medicine Committee represents the adult medical services provided in the medical/surgical and intensive care unit departments. Whenever possible, the cardiopulmonary Medical Director and an Outpatient Medicine Committee representative shall serve on the committee. The medical/surgical nurse manager and the Administrator (or designee), as well as representatives from the respiratory therapy, physical therapy, dietary, and pharmacy departments shall be non-voting ex-officio members. Other departments may participate as needed by invitation. As available, the Administrator shall designate a District quality representative to this committee in a non-voting capacity.

(c) Outpatient Medicine Committee

The Outpatient Medicine Committee represents the outpatient services including family medicine, internal medicine, outpatient infusion department, and other outpatient medicine departments not represented by other committees. Whenever possible, the cardiopulmonary Medical Director and

an Inpatient Medicine Committee representative shall serve on the committee. The clinical nurse manager, a representative from the outpatient infusion department, and the Administrator (or designee) shall be non-voting ex-officio members. Other departments may participate as needed by invitation. As available, the Administrator shall designate a District quality representative to this committee in a non-voting capacity.

(d) Perinatal/Pediatrics Committee

The Perinatal/Pediatrics Committee shall represent the pediatric and obstetrical departments. The nurse managers of the perinatal and pediatrics units and the Administrator (or designee) shall be ex-officio non-voting members. Other departments may participate as needed by invitation. As available, the Administrator shall designate a District quality representative to this committee in a non-voting capacity.

(e) Radiology Services Committee

The Radiology Services Committee represents the radiology services. The director of diagnostic services and the Administrator (or designee) shall be non-voting ex officio members. Other departments may participate as needed by invitation. As available, the Administrator shall designate a District quality representative to this committee in a non-voting capacity.

(f) Surgery/Tissue/Transfusion/Anesthesia Committee

The Surgery/Tissue/Transfusion/Anesthesia (STTA) Committee represents all surgical, anesthesia, and pathology services. The director of perioperative nursing and the Administrator (or designee) shall serve as ex-officio non-voting members. Other departments may participate as needed by invitation. As available, the Administrator shall designate a District quality representative to this committee in a non-voting capacity.

~~11.12-211.11-2~~ DUTIES

The Medical Staff departmental committees listed in Section 11.12-1 are responsible for overseeing the quality and appropriateness of patient care rendered in the department by, without limitation:

- (a) Using critical indicators to conduct concurrent and retrospective peer review of medical records with referral for committee review as indicated;
- (b) Monitoring and evaluating clinical performance of all privileged practitioners attending patients or administering care in the department;
- (c) Periodically reviewing and evaluating the medical services provided;
- (d) Making recommendations concerning matters for which the committee is responsible to the Medical Executive Committee and the Administrator or Chief Medical Officer as appropriate;
- (e) Reviewing applicants for privileges when requested by the Department Chief;
- (f) Electing annually the departmental committee Chair, who presides over the meetings and attends the Medical Executive Committee meetings. This departmental committee Chair may or may not be the Chief of the department; and
- (g) Receiving reports from other committees as appropriate.

~~11.12-311.11-3~~ MEETINGS AND REPORTS

The Medical Staff departmental committees shall meet at least quarterly. The committees shall report a summary of their activities or findings to the Medical Executive Committee on a regular basis. The committees shall also give notification to the Medical Executive Committee promptly after the committees receive notice of any matter for which a practitioner is required to give notice to the Medical Staff pursuant to these Bylaws, if not already reported.

ARTICLE XII: MEETINGS

12.1 GENERAL MEDICAL STAFF MEETINGS

12.1-1 REGULAR MEETINGS

Regular meetings of the Medical Staff members shall be held at least quarterly. The date, place and time of the regular meetings shall be determined by the Medical Executive Committee or the Chief of Staff, and adequate notice shall be given to the members.

12.1-2 AGENDA

The order of business at a meeting of the Medical Staff shall be determined by the Chief of Staff and Medical Executive Committee. The agenda shall include, as applicable:

- (a) reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;
- (b) administrative reports from the Chief of Staff, departments, committees, and the Administrator or designee;
- (c) election of officers when required by these Bylaws;
- (d) old business; and
- (e) new business.

12.1-3 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Chief of Staff or the Medical Executive Committee, or shall be called upon the written request of ten percent (10%) of the members of the active Medical Staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled as soon as reasonably possible, but within thirty (30) days after receipt of such request. Notice shall be given to the members of the staff with as much advance notice as possible, which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

12.2 COMMITTEE AND DEPARTMENT MEETINGS

12.2-1 REGULAR MEETINGS

Except as otherwise specified in these Bylaws, the Chairs of Medical Staff and departmental committees may establish the times for the holding of regular meetings. The Chairs shall make every reasonable effort to ensure the meeting dates are disseminated to the members with adequate notice.

12.2-2 SPECIAL MEETINGS

A special meeting of any Medical Staff committee or department may be called by the Chair thereof, the Medical Executive Committee, or the Chief of Staff.

12.3 QUORUM

12.3-1 GENERAL MEDICAL STAFF MEETINGS

The presence of fifty percent (50%) of the total members of the active Medical Staff at any regular or special meeting in person or through written (electronic) ballot shall constitute a quorum for the purpose of the election or removal of Medical Staff Officers, or other special votes as determined by the Chief of Staff. The presence of twenty-five percent (25%) of members shall constitute a quorum for all other actions.

12.3-2 DEPARTMENT MEETINGS

For department committees, a quorum shall consist of two physicians.

12.3-3 MEDICAL STAFF COMMITTEE MEETINGS

A quorum of fifty percent (50%) of the voting members shall be required for Medical Executive Committee meetings. For other Medical Staff committee meetings (e.g., utilization review, ~~pharmacy and therapeutics~~), the presence of two (2) committee voting members shall constitute a quorum, unless otherwise specified in the committee composition.

12.4 VOTING AND MANNER OF ACTION

12.4-1 VOTING

Unless otherwise specified in these Bylaws, only members of the active Medical Staff may vote in Medical Staff general meetings and elections. All members of the Medical Staff and APP staff are entitled to vote at committee and department meetings appropriate to their specialty as described at time of appointment.

12.4-2 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these Bylaws. A meeting in which a quorum is not initially present may be started, though no action may be taken until a quorum is present. Committee and Medical Staff action may be conducted by telephone conference or other electronic communication. Votes collected by electronic means require a majority vote to be valid.

12.5 MINUTES

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters.

12.6 ATTENDANCE REQUIREMENTS

12.6-1 REGULAR ATTENDANCE

Members are expected to attend all meetings of the Medical Staff and of the department or committee to which assigned. Attendance via telephone conference or other electronic communication shall be accepted. Each member of the consulting or courtesy staff shall be required to attend such meetings as may be determined by the Medical Executive Committee.

12.6-2 ABSENCE FROM MEETINGS

Any member who is compelled to be absent from any Medical Staff, department, or committee meeting shall promptly provide to the regular presiding officer thereof the reason for such absence. Unless excused for good cause by the presiding officer of the department or committee, or the Medical Staff Office for Medical Staff

meetings, failure to attend may be included in the practitioner's ongoing professional practice evaluation, reviewed by the Medical Executive Committee, and may be grounds for removal from such committee or for corrective action.

12.6-3 SPECIAL ATTENDANCE

At the discretion of the Chair or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular department or committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a member to appear at any meeting to which notice was given, unless excused by the Medical Executive Committee upon a showing of good cause, shall be a basis for corrective action.

12.7 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order; however, technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

12.8 EXECUTIVE SESSION

The Chairperson of any standing, special, or ad hoc committee of the Medical Staff, including departments, may call an executive session meeting. Only members of the active Medical Staff holding voting privileges on the committee shall attend the executive session meeting. The Chairperson, at his or her discretion, may request other individuals to attend the meeting in an informational capacity. Executive session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring confidentiality.

ARTICLE XIII: CONFIDENTIALITY, IMMUNITY AND RELEASES

13.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising clinical privileges within Northern Inyo Healthcare District, an applicant:

- (a) authorizes representatives of the District and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;
- (b) authorizes persons and organizations to provide information concerning such practitioner to the Medical Staff;
- (c) agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the District who would be immune from liability under Section 13.3 of this Article; and
- (d) acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of clinical privileges at this District.

13.2 CONFIDENTIALITY OF INFORMATION

13.2-1 GENERAL

The minutes, files, records and proceedings of the Medical Staff and all departments and standing or ad hoc committees, including information regarding any applicant, member or other individual exercising clinical privileges or practice privileges, shall be considered Medical Staff minutes or records and, to the fullest extent permitted by law, shall be confidential and protected from discovery pursuant to California Evidence Code Section 1157 and any other applicable peer review or other policy or privilege. This information shall become part of the Medical Staff committee files and shall not become part of any patient files, general District records, or any member's personal or office files.

Dissemination of such information and records shall only be made where expressly required by law, as authorized by these Bylaws, or pursuant to officially adopted policies of the Medical Staff or, where no officially adopted policy exists, only with the express approval of the Chief of Staff and the Administrator.

13.2-2 BREACH OF CONFIDENTIALITY

As effective peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff departments or committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff, violates the Medical Staff Bylaws, and will be deemed disruptive to the operations of the District. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

13.2-3 ACCESS TO AND RELEASE OF CONFIDENTIAL INFORMATION

All requests for access to Medical Staff records, including confidential committee records and credential files, shall be presented to an authorized representative. Authorized representatives include the authorized Medical Staff Office personnel and Medical Staff Officers.

(a) Access for Official Purposes

- (1) The following individuals may access Medical Staff records, including confidential committee records and credentials files, to the extent described:
 - i. Committee members and their authorized representatives, for the purpose of conducting authorized committee functions.
 - ii. Medical staff and department officials, and their authorized representatives, for the purpose of fulfilling any authorized function of such official.
 - iii. The Administrator, the Board of Directors, and their authorized representatives, for the purpose of enabling them to discharge their lawful obligations and responsibilities. Information which is disclosed to the Board of Directors or its appointed representatives shall be maintained as confidential.
 - iv. Consultants or attorneys engaged by the District may be granted access to credential files that are necessary to enable them to perform their functions, if an authorized Medical Staff representative agrees.
 - v. Representatives of licensure agencies, accreditation agencies, or auditors from Medicare or Medicaid, if an authorized representative is with them.
- (2) All subpoenas pertaining to Medical Staff records, including confidential committee records and credentials files, shall be referred to the Medical Staff Office, who shall first consult with the Administrator, the Chief of Staff, and legal counsel regarding appropriate response.

(b) Limits on Access to Practitioner's Credentials File

- (1) A practitioner can view the contents of his or her credentials file, as described below, during normal business hours upon reasonable prior request to the Chief of Staff or Medical Staff Officer. The individual only has the right to review and receive a copy of documents provided by or addressed personally to the individual practitioner. The Medical Staff has discretion to disclose other documents to a member, but in no case shall copies of confidential letters of reference, hospital verifications or other confidential correspondence be disclosed. An individual practitioner may review the above identified parts of his or her credentials file under the following circumstances:
 - i. Review of the credentials file is accomplished in the presence of one of the following: authorized Medical Staff Office personnel, officer of the Medical Staff, a member of the Credentials Committee, or Department Chief.
 - ii. The practitioner understands that he or she may not remove any items from the credentials file.
 - iii. The practitioner understands that, subject to review by the Chief of Staff, he or she may add an explanatory note or other document to the file.
 - iv. The practitioner understands that he or she may not review confidential letters of reference, hospital verifications or other confidential correspondence received by the District or the Medical Staff.

- v. Documents provided by the practitioner for inclusion in the credentials file (e.g., Curriculum Vitae, licenses, insurance policy, continuing medical education) may be photocopied. No other items may be photocopied without the express permission of the credentials Chair.

(c) Medical Staff Committee Files and Minutes

- (1) Any member shall be allowed access to minutes or other Medical Staff records which describe meetings or activities of the Medical Staff committees that they were entitled to attend (e.g. their department committees of which they are members). This does not include minutes or records of meeting or activities from which the practitioner was specifically excluded.

13.3 IMMUNITY FROM LIABILITY

13.3-1 FOR ACTION TAKEN

Each representative of the Medical Staff and District shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or District.

13.3-2 FOR PROVIDING INFORMATION

Each representative of the Medical Staff and District and all third parties shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the Medical Staff or District concerning such person who is, or has been, an applicant to or member of the staff or who did, or does, exercise clinical privileges or provide services at this District.

13.4 ACTIVITIES AND INFORMATION COVERED

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other healthcare facility's or organization's activities concerning, but not limited to:

- (a) application for appointment, reappointment, or clinical privileges;
- (b) corrective action;
- (c) hearings and appellate reviews;
- (d) utilization reviews;
- (e) other department, committee or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and
- (f) queries and reports concerning the National Practitioner Data Bank, peer review organization, the Medical Board of California, and similar queries and reports.

13.5 RELEASES

Each applicant or member shall, upon request of the Medical Staff or District, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

13.6 INDEMNIFICATION

Northern Inyo Healthcare District shall indemnify, defend and hold harmless the Medical Staff, its individual members, and its appointed representatives (e.g. expert witnesses, lay committee members, hearing officers) from and against losses and expenses (including attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review, quality assessment, or activities related to establishing standards, policies and/or procedures pursuant to the self-governing Medical Staff provisions, including, but not limited to:

- (a) as a member of or witness for a Medical Staff department, service, committee or hearing panel;
- (b) as a member of or witness for the District Board or any District task force, group, or committee, and;
- (c) as a person providing information to any Medical Staff or hospital group, officer, Board member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a Medical Staff member or applicant.

The Medical Staff or member may seek indemnification for such losses and expenses under this Bylaws provision, statutory and case law, any available liability insurance or otherwise as the Medical Staff or member sees fit, and concurrently or in such sequence as the Medical Staff or member may choose. Payment of any losses or expenses by the Medical Staff or member is not a condition precedent to the District's indemnification obligations hereunder. In no event will the District indemnify an indemnitee for acts or omissions taken in bad faith or in pursuit of the indemnitee's private economic interests.

ARTICLE XIV: GENERAL PROVISIONS

14.1 DUES OR ASSESSMENTS

The Medical Executive Committee shall have the power to recommend the amount of annual dues or assessments, if any, for each category of Medical Staff membership, subject to the approval of the Medical Staff, and to determine the manner of expenditure of such funds received.

Failure of a member to pay dues or assessments, without good cause as determined by the Medical Executive Committee, will be included in the member's ongoing professional practice evaluation and may be grounds for corrective action.

14.2 AUTHORITY TO ACT

Any member or members who act in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee may deem appropriate.

14.3 DIVISION OF FEES

Any division of fees by members of the Medical Staff is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff.

14.4 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests required or permitted to be mailed shall be in writing properly sealed, and shall be sent through United States Postal Service. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained. Notice to the Medical Staff or officers or committees thereof, shall be addressed as follows:

Name and proper title of addressee
Name of department or committee
[c/o Medical Staff Office, Chief of Staff]
Hospital name
Street address
City, State, Zip code

Mailed notices to a member, applicant or other party shall be to the addressee at the address as it last appears in the official records of the Medical Staff or District.

14.5 DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff Offices, Department Chief, or the Medical Executive Committee shall, at least twenty (20) days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. Further information on conflict of interest may be found in Northern Inyo Healthcare District's compliance program.

14.6 RETALIATION PROHIBITED

Neither the Medical Staff, its members, committees or department heads, the Board of Directors, its Chief Executive Officer, or any other employee or agent of the District or Medical Staff, may engage in any punitive or retaliatory action

against any member of the Medical Staff because that member claims a right or privilege afforded by, or seeks implementation of any provision of, these Medical Staff Bylaws.

ARTICLE XV: ADOPTION AND AMENDMENT OF BYLAWS AND POLICIES

15.1 BYLAWS

15.1-1 PROCEDURE FOR PROPOSALS

Proposals to adopt, amend or repeal the Bylaws may be initiated by either of the following methods:

- (a) The Medical Executive Committee, with the recommendation of the Bylaws Committee, or on its own motion, may recommend adoption, amendment or repeal of the Bylaws to the voting members of the Medical Staff as provided in this Article.
- (b) The members of the active staff, by a written petition signed by at least twenty percent (20%) of the active staff members, may petition the Medical Executive Committee to initiate a proposal to adopt, amend or repeal the Bylaws. Such petition shall identify exact language to be added, changed or deleted. If the Medical Executive Committee agrees with the proposed change, it may recommend the change as provided in subsection (a), above.

15.1-2 APPROVAL BY THE ACTIVE STAFF

If a proposal is initiated as provided above, the Chief of Staff shall inform the members of the active staff of the proposed change, by mail ~~or~~, by electronic means, of the proposed change or at a meeting of the Medical Staff. Voting on proposals shall take place Not-not less than thirty (30) days and not more than ninety (90) days from the date of such notice, ~~the Chief of Staff shall either call a special meeting of the Medical Staff or add it to the agenda of a regular meeting to consider the proposed change.~~

To be adopted, a proposed change must be approved by a majority of the members of the active staff ~~voting in person or by written ballot. If a written ballot is used, the ballots shall be opened and counted at the meeting and the results shall be announced.~~

15.1-3 APPROVAL BY THE DISTRICT BOARD

Upon action by the active staff as provided above, the proposed change shall be submitted to the Board of Directors for approval. The Board of Directors may not unreasonably withhold its approval from the active staff's recommended change. If the Board of Directors votes to disapprove any part of the recommended change, the Board of Directors shall give the Chief of Staff written notice of the reasons for non-approval within ten (10) business days from the Board of Directors' action. At the request of the Medical Executive Committee, the Board of Directors' disapproval shall be submitted to the Joint Conference Committee for resolution.

15.2 MEDICAL STAFF POLICIES

15.2-1 PROCEDURE FOR PROPOSALS

Proposals to adopt, amend or repeal the Medical Staff policies may be initiated by any active Medical Staff member or Medical Staff committee.

15.2-2 APPROVAL

- (a) Approval by the appropriate Medical Staff committee(s), as applicable;
- (b) Approval by the Medical Executive Committee;
- (c) Approval by the active Medical Staff; and

- (d) Submission to the Board of Directors for approval. If the Board of Directors disapproves the policy, it will be referred back to the appropriate committee(s).

15.3 TECHNICAL AND EDITORIAL AMENDMENTS

Notwithstanding any other provision of the Bylaws to the contrary, the Medical Executive Committee shall have authority on behalf of the Medical Staff to approve such amendments to the Bylaws or policies as the Medical Executive Committee deems to be necessary or appropriate to correct or clarify punctuation, spelling, grammatical or expression errors or ambiguities; cross references; numbering or organization; names or titles of committees, officers, practitioner categories, or other such identifiers. The Medical Executive Committee shall give notice of such amendments to the Medical Staff members, the Administrator, and the District Board. Such amendments shall become effective upon approval by the District Board.

15.4 DISTRIBUTION OF APPROVED PROPOSALS

Promptly after approval, and if reasonably practical, prior to the proposal's effective date, a copy of an approved proposal for Bylaws or policies changes shall be distributed to all members, applicants, and other privileged practitioners and APPs who hold any type of privileges pursuant to the Bylaws.

The Northern Inyo Healthcare District Medical Staff Bylaws are:

ADOPTED by the Medical Staff on

_____, 20____
Date

Chief of Staff

Vice Chief of Staff

APPROVED by the Board of Directors on

_____, 20____
Date

Board Chair

Board Secretary



DATE: July 15, 2026
 TO: Board of Directors, Northern Inyo Healthcare District
 FROM: Christian Wallis, CEO
 RE: Finding of Exemption from Appropriations Limit

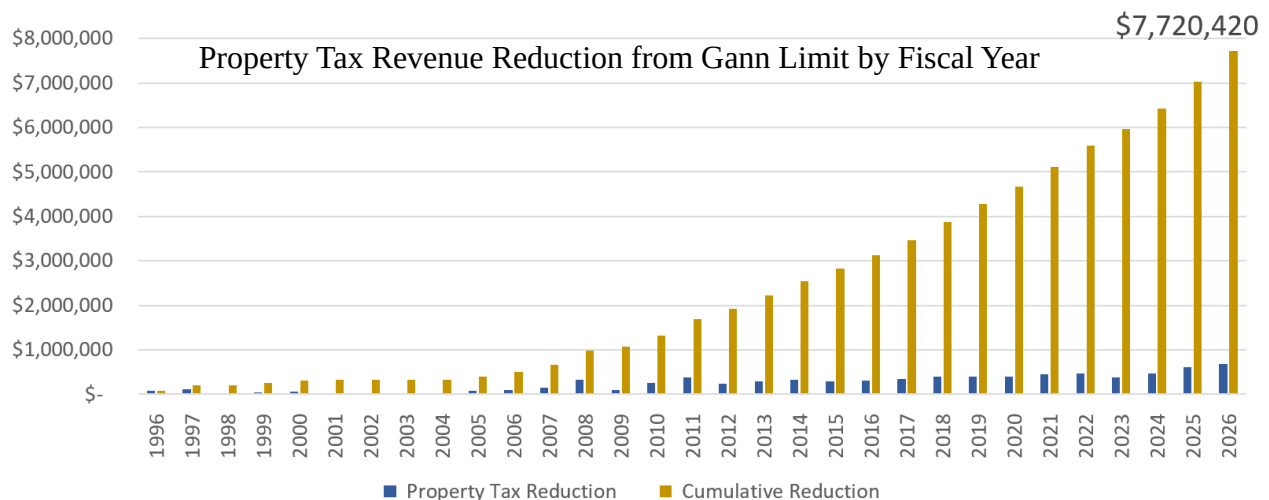
MEMORANDUM

Background

Gann Appropriations Limit

While Tom Scaglione of ATS Financial Services was engaged by NIH to assist in debt service administration, he discovered a rate listed on Inyo County's *Tax Rates by Tax Rate Area* report as "1995 NORTHERN INYO HOSPITAL 220-NORTHERN INYO HOSPITAL GANN REFUND".

California Proposition 4 (1979), also known as the Gann limit, was approved by voters with the goal of keeping state and local government spending capped at 1978-79 levels, adjusted for changes in population and inflation. The Gann limit caps the 1% *ad valorem* property tax apportionment and is codified in the California Constitution (Article XIII B) and Government Code §7900-7914. NIH calculates and adopts the limit every year. The limit resulted in NIH's general property tax revenue being reduced by \$7.7 million over the past 30 years, at an estimated \$12.6 million in present value.



NIH is the only taxing authority within Inyo County whose *ad valorem* tax is reduced by a Gann limit. NIHD is one of a few, if any, special districts in California whose tax revenue is limited by Gann. Many special districts are exempt from Gann as California Constitution Article XIII B Section 9(c) and California Government Code section 7901(e) provides that any special district

which ***did not levy an ad valorem property tax rate in excess of 12 1/2 cents per one hundred dollars (\$100) of assessed value for the 1977-78 fiscal year*** is exempt from Gann limitation.

NIH is exempt from Gann as their *ad valorem* property tax revenue for the 1977-78 fiscal year per audited financial statements was less than 6% of assessed values (less than 6 cents per one hundred dollars of assessed value for the 1977-78 fiscal year).

NIH staff and Mr. Scaglione virtually met with Ms. Amy Shepherd, Inyo County Auditor-Controller, on May 13, 2026. On June 3, 2026, upon Ms. Shepherd's request, CEO Wallis sent Ms. Shepherd, via email, a letter providing support for the suspension of the Gann Appropriations Limit calculation and refund assessment.

Discussion

Rather than adopting a Gann resolution to provide the appropriations limit to the County, staff is recommending the Board adopt a resolution recognizing NIH's exempt status and requesting the County remove the Gann Refund credit from the tax roll.

Recommendation

Administration recommends that the Board consider adopting a Resolution to determine the District is exempt from the Gann appropriations limit calculation and notify Inyo County to no longer reduce NIH's share of the 1% *ad valorem* general property tax by a Gann Refund.

**NORTHERN INYO HEALTHCARE DISTRICT
DISTRICT BOARD RESOLUTION 26-02
Finding of Exemption from Appropriations Limit**

WHEREAS, historically, the Northern Inyo Healthcare District has established an annual appropriations limit in accordance with Article XIII B of the California Constitution; and

WHEREAS, it has been since determined that Northern Inyo Healthcare District is exempt from the Gann appropriations limit in accordance with the California Constitution Article XIII B Section 9(c) and California Government Code section 7901(e) which exempts special districts that did not levy an ad valorem property tax rate in excess of 12½ cents per one hundred dollars (\$100) of assessed value (12.5% of assessed values) for the 1977-78 fiscal year. Northern Inyo Healthcare District's ad valorem property tax revenue for the 1977-78 fiscal year per audited financial statements was less than \$226,219 which is less than 6% of assessed values at that time.

NOW, THEREFORE, BE IT RESOLVED by this Board of Directors of Northern Inyo Healthcare District, meeting in regular session this 15th day of July, 2026 finds that the Northern Inyo Healthcare District's ad valorem property tax revenue for the 1977-78 fiscal year per audited financial statements was less than \$226,219 which is less than 6% of assessed values at that time, and that the District is exempt from Gann appropriations limit in pursuant to California Constitution Article XIII B Section 9(c) and California Government Code section 7901(e).

BE IT FURTHER RESOLVED that as a special district exempt from annual Gann calculations pursuant to California Constitution Article XIII B Section 9(c) and California Government Code section 7901(e), the District will no longer provide Inyo County with an appropriations limit.

BE IT FURTHER RESOLVED that as a special district exempt from the Gann appropriations limit pursuant to California Constitution Article XIII B Section 9(c) and California Government Code section 7901(e), Northern Inyo Healthcare District is entitled receive 100% of its apportionment of the ad valorem property tax assessed on all property within the District subject to taxation in accordance with Article XIII B of the California Constitution and California Government Code section 7901(e). The Board of Directors requests that Inyo County Auditor-Controller remove the "1995 NORTHERN INYO HOSPITAL 220-NORTHERN INYO HOSPITAL GANN REFUND" from the tax roll.

BE IT FURTHER RESOLVED that the Clerk of the Board is hereby directed to provide notice of this Resolution to the Inyo County Auditor-Controller.

BE IT FURTHER RESOLVED that this Resolution be made a part of the minutes of this meeting; and this Resolution shall take effect immediately after its adoption on the date hereof.

PASSED, APPROVED, AND ADOPTED by the Northern Inyo Healthcare District this 15th day of July 2026 by the following vote:

AYES: _____
NOES: _____
ABSTAIN: _____
ABSENT: _____

By: _____
Melissa Best-Baker, Chair of the Board
Northern Inyo Healthcare District

ATTEST: _____
Clerk of the Board
Northern Inyo Healthcare District



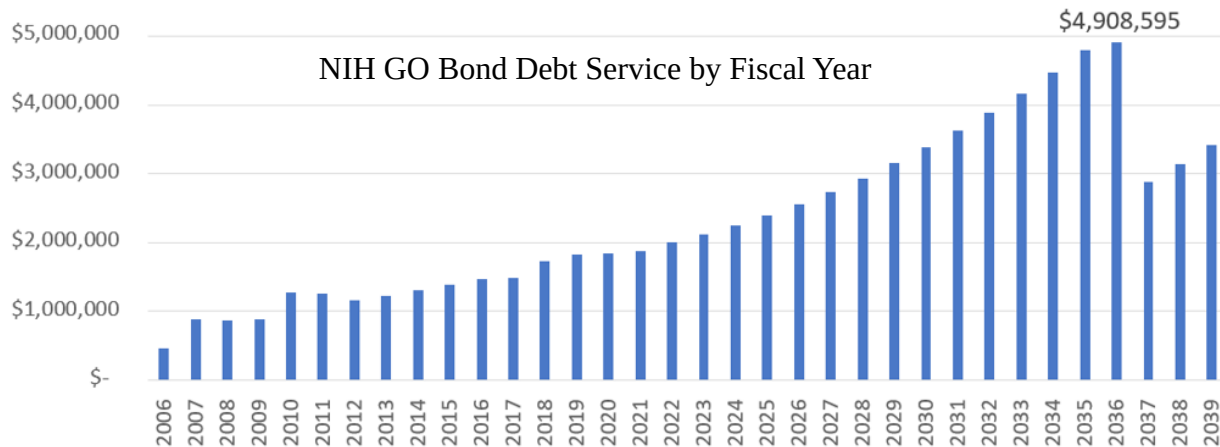
DATE: July 15, 2026
TO: Board of Directors, Northern Inyo Healthcare District
FROM: Christian Wallis, CEO
RE: Property Tax Rates

MEMORANDUM

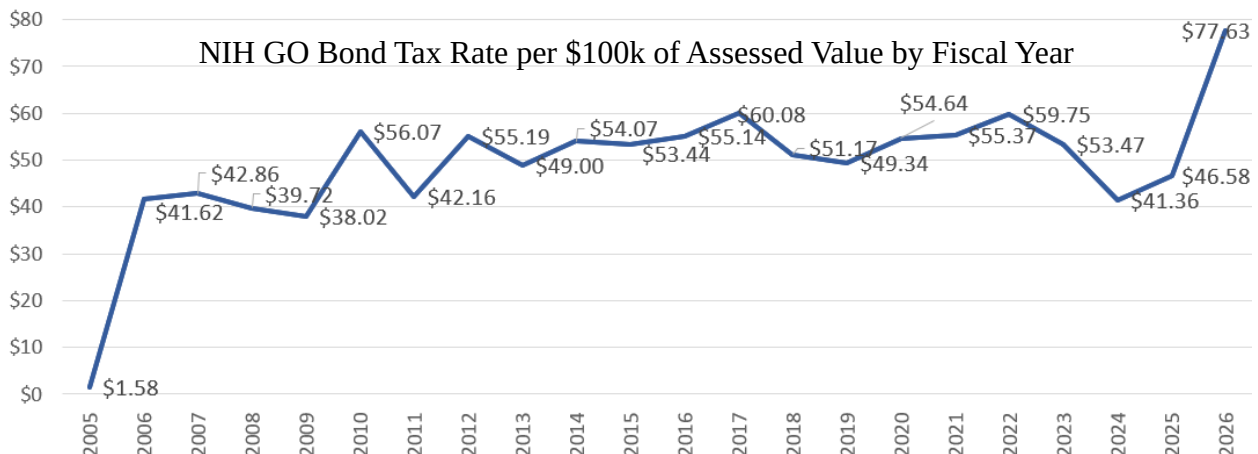
Background

GO Bond Property Tax Rate

Northern Inyo Healthcare District's General Obligation (GO) Bond debt service requirement changes every year, escalating at an average of 7.6% annually.



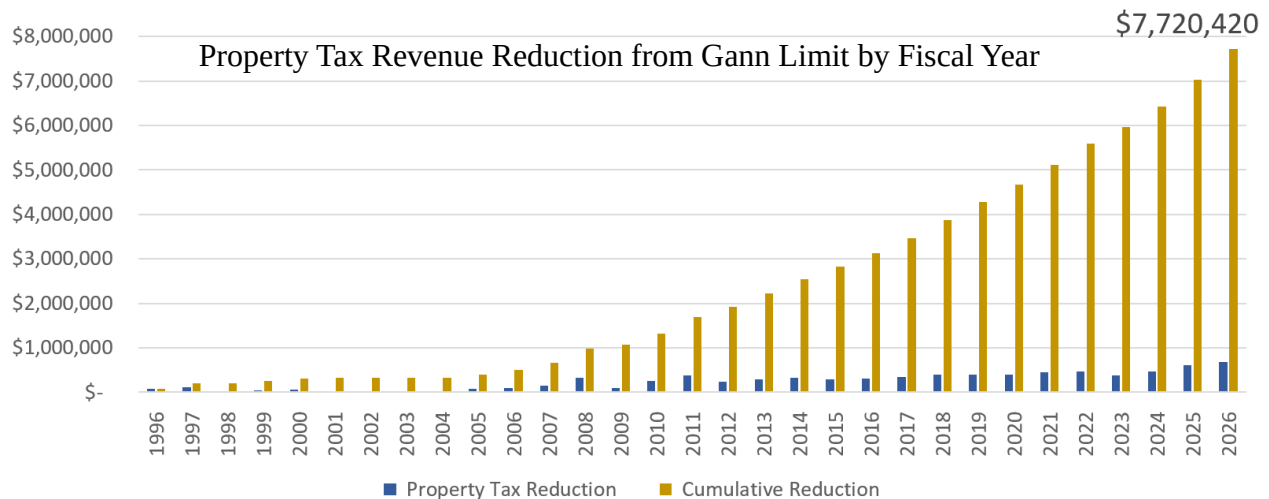
Each year, NIH provides Inyo County with the upcoming year's GO Bond debt service requirement and the County calculates the GO Bond rate to assess on the property tax roll. The County's calculation does not take into account future debt escalation or a reserve to stabilize the rate. The rate changes every year.



Gann Appropriations Limit

While Tom Scaglione of ATS Financial Services was engaged by NIH to assist in debt service administration, he discovered a rate listed on Inyo County's *Tax Rates by Tax Rate Area* report as "1995 NORTHERN INYO HOSPITAL 220-NORTHERN INYO HOSPITAL GANN REFUND".

California Proposition 4 (1979), also known as the Gann limit, was approved by voters with the goal of keeping state and local government spending capped at 1978–79 levels, adjusted for changes in population and inflation. The Gann limit caps the 1% *ad valorem* property tax apportionment and is codified in the California Constitution (Article XIII B) and Government Code §7900-7914. NIH calculates and adopts the limit every year. The limit resulted in NIH's general property tax revenue being reduced by \$7.7 million over the past 30 years, at an estimated \$12.6 million in present value.



NIH is the only taxing authority within Inyo County whose *ad valorem* tax is reduced by a Gann limit. NIHD is one of a few, if any, special districts in California whose tax revenue is limited by Gann. Many special districts are exempt from Gann as California Constitution Article XIII B Section 9(c) and California Government Code section 7901(e) provides that any special district which ***did not levy an ad valorem property tax rate in excess of 12 1/2 cents per one hundred dollars (\$100) of assessed value for the 1977-78 fiscal year*** is exempt from Gann limitation.

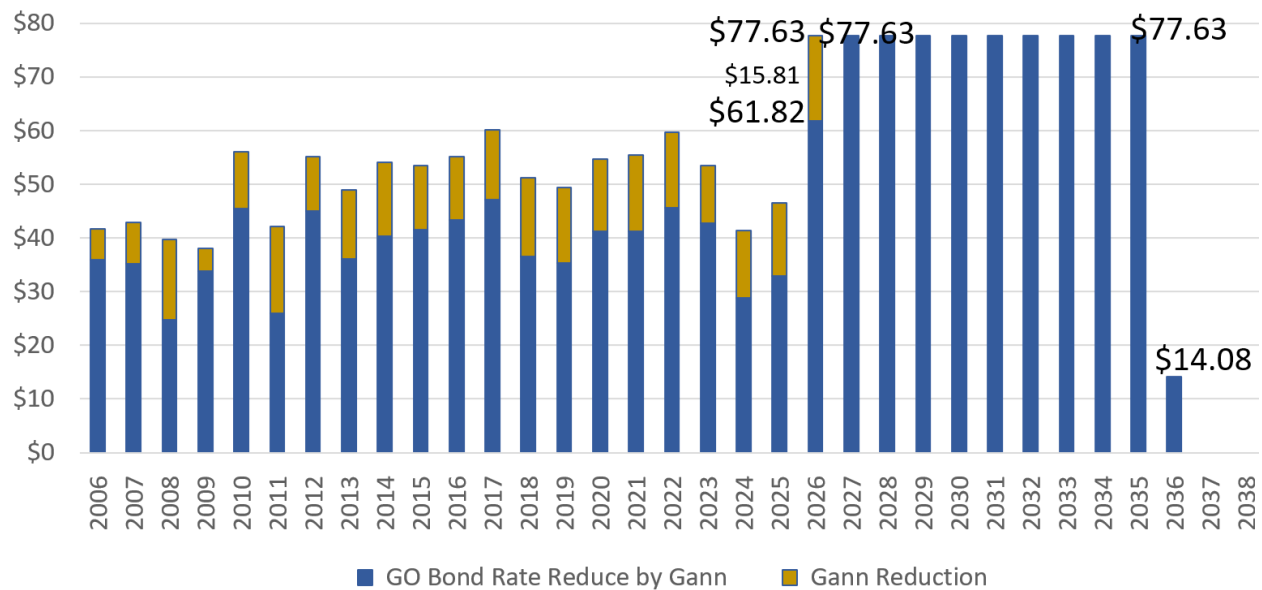
NIH qualifies for this exemption, as its audited financial statements confirm that its *ad valorem* property tax revenue for the 1977-78 fiscal year was less than 6% of assessed values (less than 6 cents per one hundred dollars of assessed value for the 1977-78 fiscal year).

In a separate agenda item, staff proposes that the Board find NIH is exempt from the annual Gann limit calculation and request that the County remove the Gann Refund application from the tax roll.

Discussion

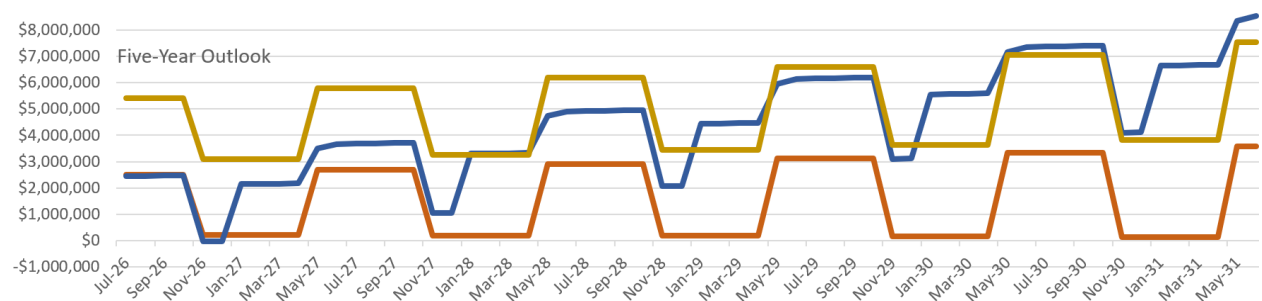
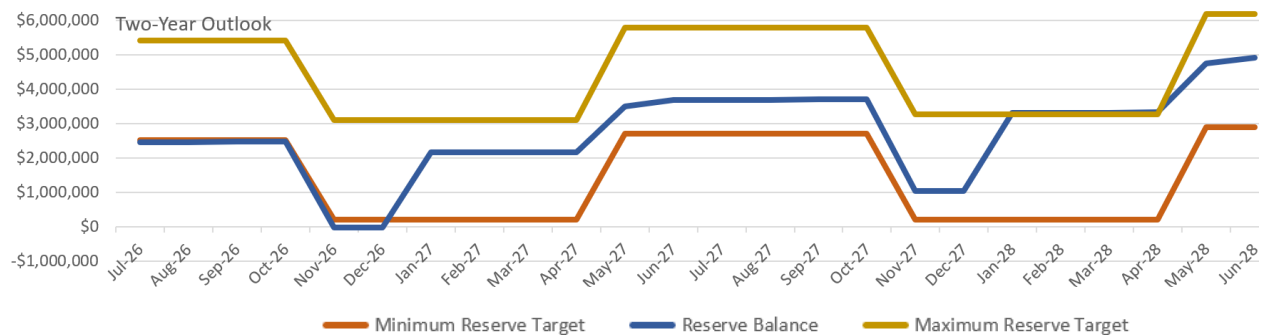
Tom Scaglione of ATS Financial Services provided NIH with a rate model that sets a consistent rate year-after-year, and builds a reserve that stabilizes the rate, anticipating only downward adjustments to the rate towards the maturity of the bonds. The following discussion provides rate options for Board consideration.

Option 1 – Keep GO Bond Rate the Same

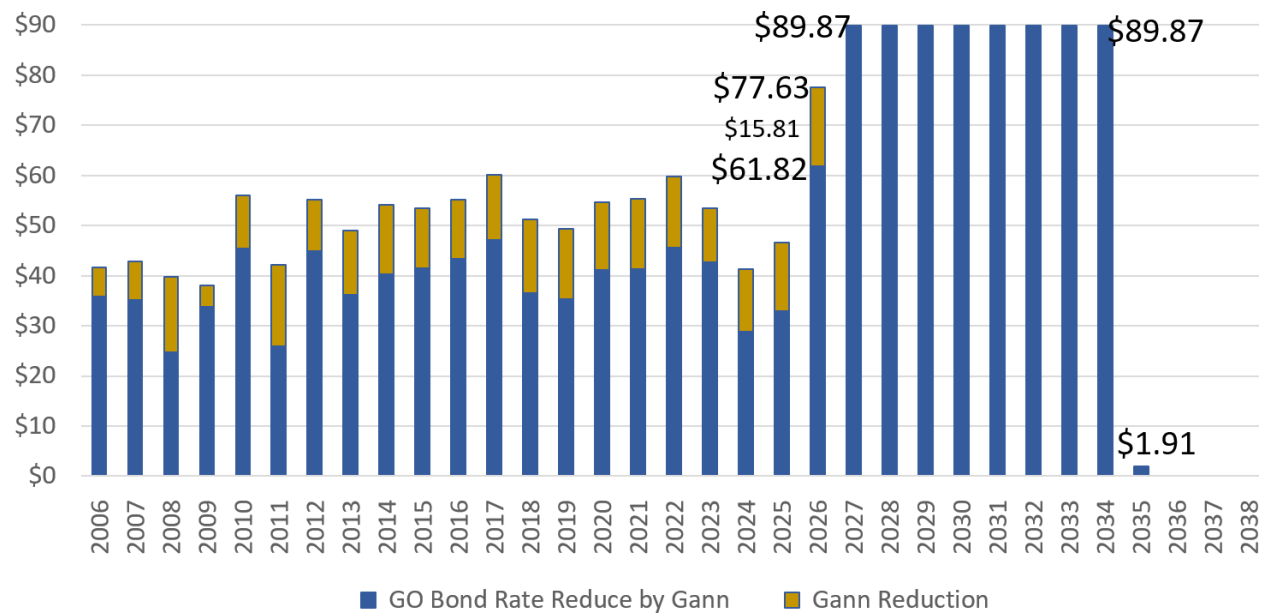


The graph above and following rate graphs show the past 20-year history of both the GO Bond rate and the Gann Refund credit and the net impact to taxpayers. In FY 2026, the GO Bond rate was \$77.63 for every \$100k of assessed value (AV) and the Gann Refund credit, which varied every year, reduced taxes by \$15.81 per \$100k of AV with the net impact to taxpayers resulting in \$61.82/\$100k AV. Keeping the GO Bond rate the same would feel like a \$15.81 rate increase, but \$15.81 was credited in error. In this rate option, if all assumptions are met, reserves can be depleted starting in FY 2036 to allow for early rate reductions ahead of the 2038 bond maturity.

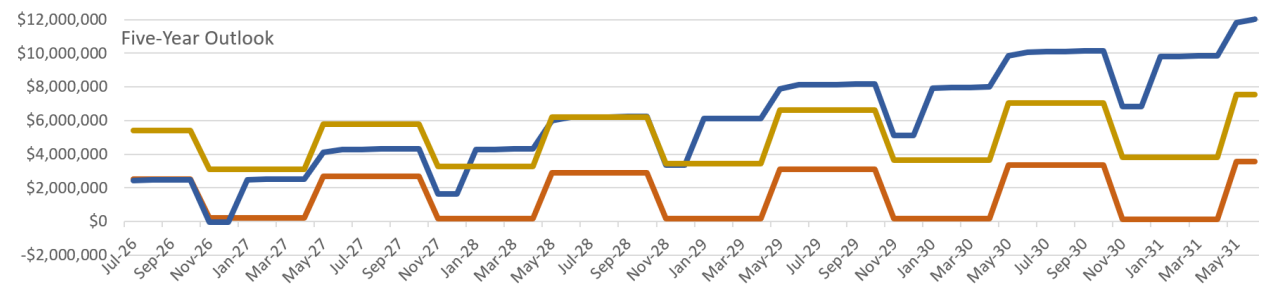
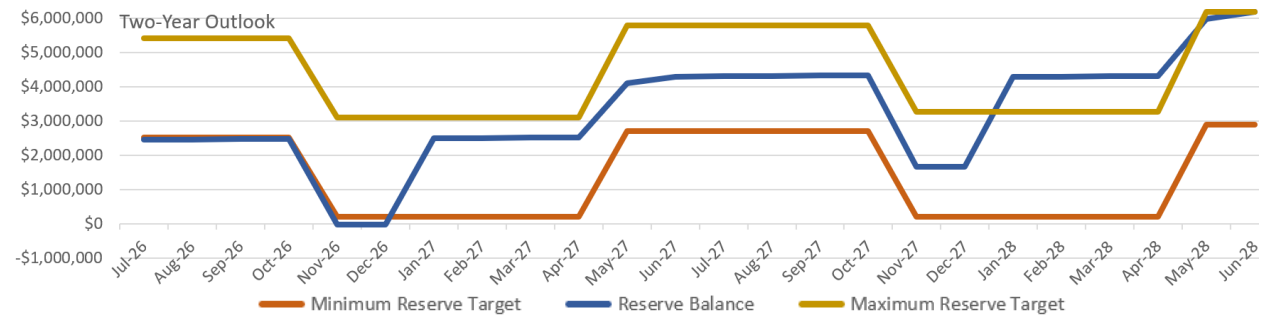
The reserve minimum is the next GO Bond semi-annual installment payment, while the maximum is the next three installment payments. The reserve balance in two years would be below the maximum reserve target, and in five years, above the maximum target.



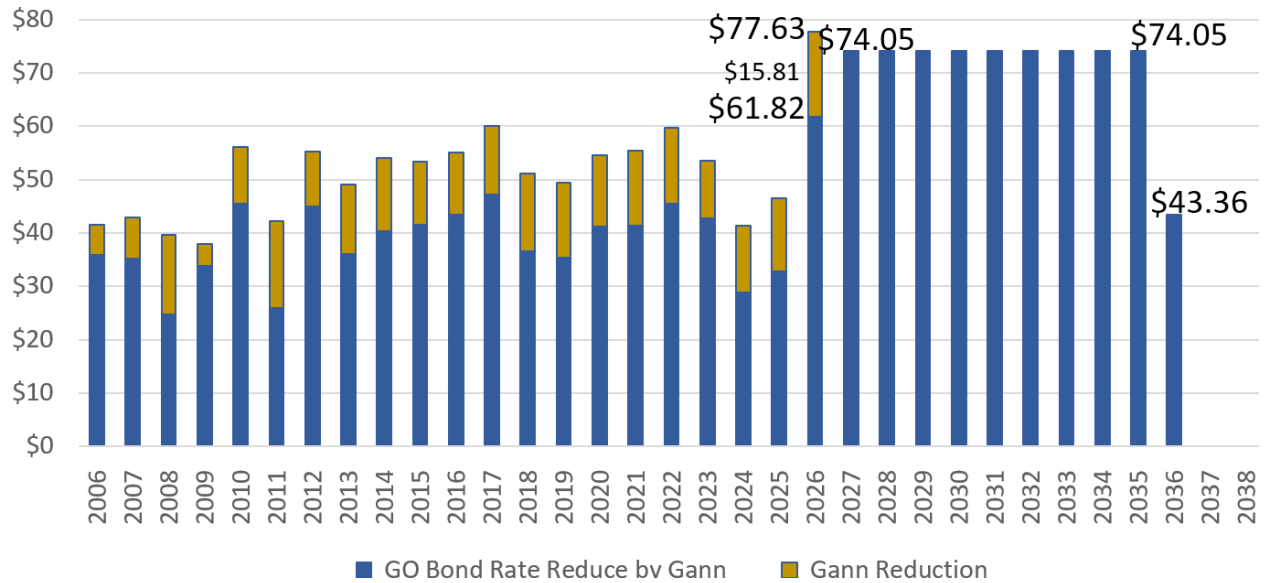
Option 2 – Fully Fund Reserve in Two Years



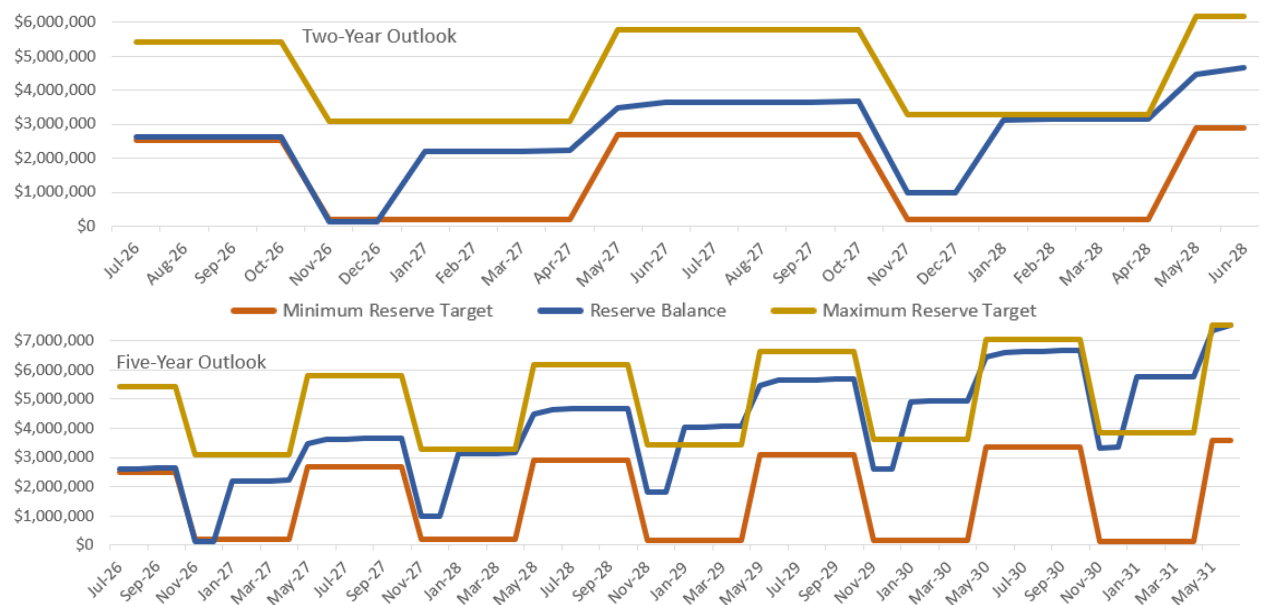
Option 2 shown above fully funds the GO Bond reserve maximum target within two years with an increase of \$12.23, 15.8%.



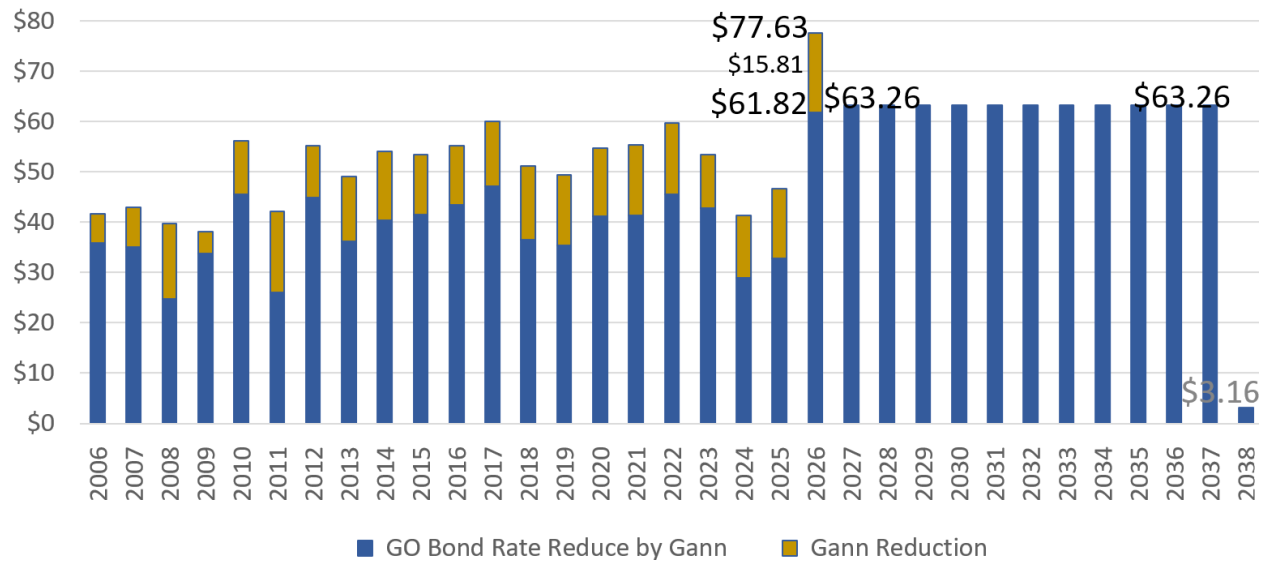
Option 3 – Fully Fund Reserve in Five Years



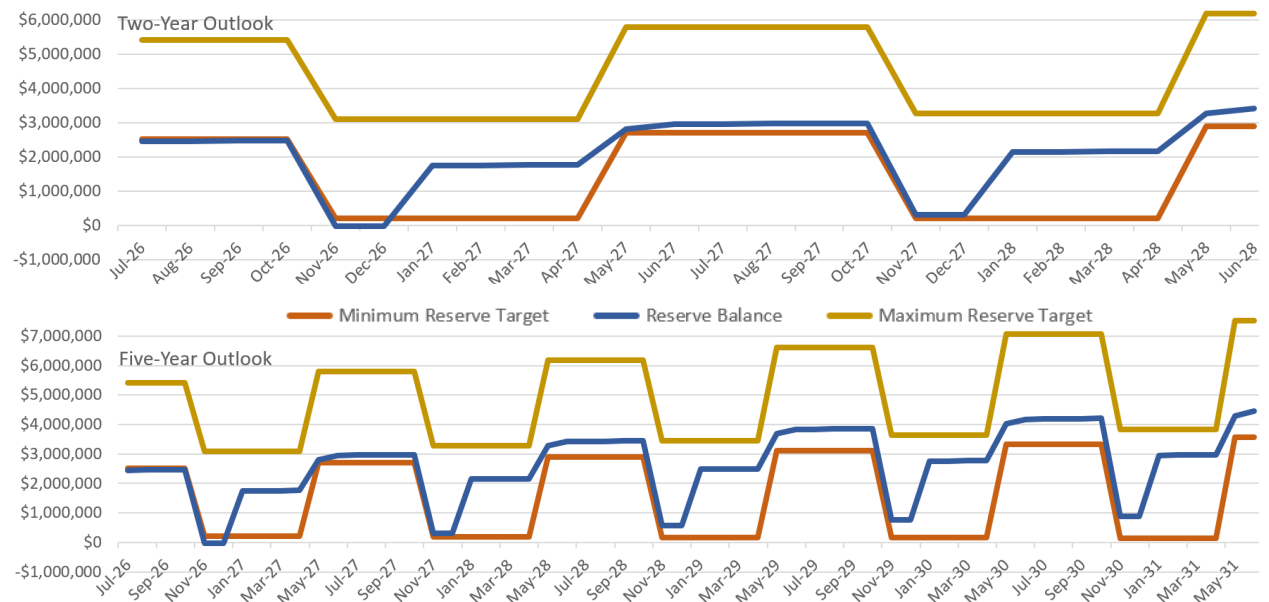
Option 3 shown above fully funds the GO Bond reserve maximum target within five years and results in a decrease of \$3.58, -4.6%.



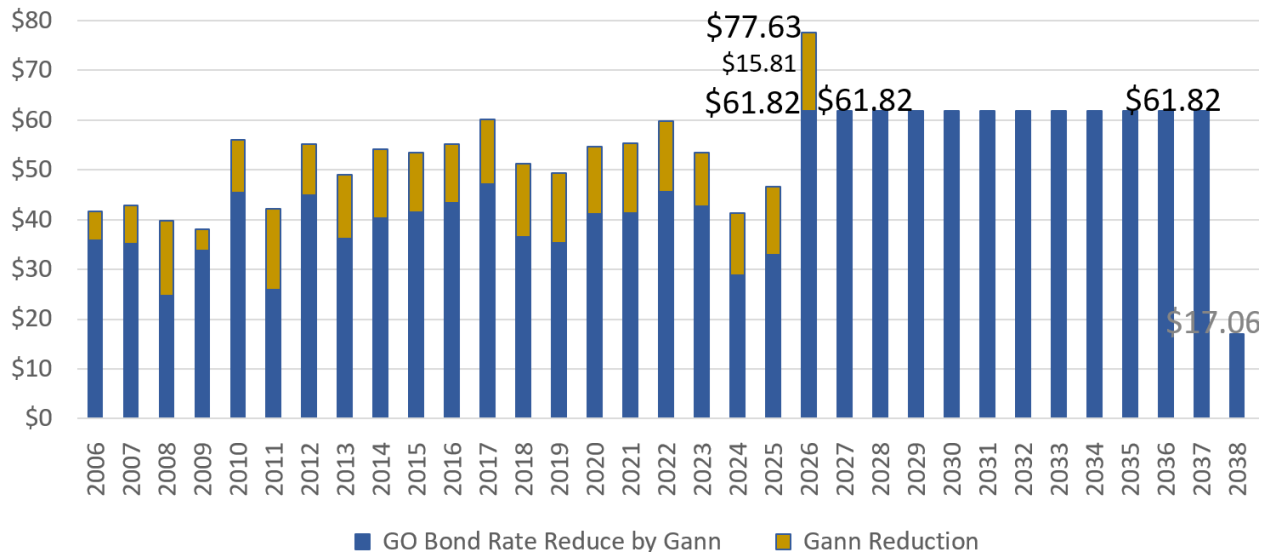
Option 4 – Disregard Reserves Targets but Maintain Reserve Above \$0



Option 4 disregards reserve targets, depletes reserves to zero, but maintains a consistent rate high enough to avoid the use of operational funds to cover GO Bond indebtedness. This results in a rate decrease of 14.37, -18.5%. This scenario will require future increases if rate model assumptions are not conservative enough.



Option 5 – Lower Rate to Prior Year’s Rate Less 2026 Gann Refund



Option 5 lowers the GO Bond rate so that there is no impact to taxpayers even after considering the removal of the Gann Refund. This option lowers the rate by \$15.81 or -20.4%. After December 2026, the reserve balance maintains above the minimum but drops below starting in May 2033, and is never fully funded. Given the assumptions, this scenario will occasionally use operating funds to pay GO bond debt service and will require future rate increases if assumptions prove to be not conservative enough.



Rate Model Assumptions

Rate Model Assumptions		
June 30, 2026 reserve balance	\$	2,443,668
Fiscal Year 2026 property tax revenue	\$	3,720,414
Annual assessed value increase		3.90%
Annual investment earnings rate at June 30, 2026		3.51%
Monthly rate of decline in investment earnings rate		-0.83%
Distribution timing of annual property tax revenue:		
	January	56.19%
	May	39.65%
	June	4.16%

Recommendation

Administration recommends that the Board consider the options discussed herein and adopt a Resolution with one of the rates discussed above.

**NORTHERN INYO HEALTHCARE DISTRICT
DISTRICT BOARD RESOLUTION 26-03**

**Resolution of the Board of Directors of the
Northern Inyo Healthcare District Requesting the Levy
of Tax on the Taxable Property of the District to Be
Collected on the Tax Rolls of the County of Inyo
for Fiscal Year 2026-27**

WHEREAS, the Northern Inyo Healthcare District (“District”) is a Special District of the State of California, organized and operating pursuant to the Health Care District Act, Health and Safety Code Section 32000 et seq.; and

WHEREAS, the issuance of general obligation bonds in one or more series in an aggregate amount not to exceed \$29,500,000 by the Northern Inyo County Hospital District (now Northern Inyo Healthcare District) was authorized by more than two-thirds of the registered voters voting at an election held on June 7, 2005; and

WHEREAS, pursuant to the laws of the State of California and a resolution of the District, the District issued an initial series of such bonds in the amount of \$15,035,000 on September 28, 2005, and a second series of its general obligation bonds in the amount of \$14,464,947.15 on April 21, 2009; and

WHEREAS, the proceeds of the bonds were used to pay costs related to the construction and equipping of the expansion and renovation of the District’s health facilities, located in Bishop, California; and

WHEREAS, the District, on May 12, 2016, issued general obligation refunding bonds in conformity with California Government Code and pursuant to a resolution of the District for redemption of all 2005 bonds and of the current interest 2009 bonds maturing November 1, 2038; and

WHEREAS, the District is empowered and obligated to cause to be levied *ad valorem* taxes, without limitation of rate or amount, upon all property within the District subject to taxation by the District (except certain personal property which is taxable at limited rates), for the payment of interest on and principal of the bonds when due;

WHEREAS, Health and Safety Code Section 32202 authorizes the County of Inyo to levy upon the taxable property of the District a tax sufficient in amount to pay the debt service on the outstanding bonds of the District as the same becomes due; and

WHEREAS, in accordance with Health and Safety Code Section 32202 the Board of Directors of the District requests that the Tax Rate be levied upon the taxable property of the District and collected on the tax rolls of the County of Inyo; and

NOW, THEREFORE, the Board of Directors of the Northern Inyo Healthcare District does hereby find, determine, resolve, and order as follows:

Section 1: For Fiscal Year 2026/2027 the District formally requests that a Tax Rate of \$XX.XXXX per \$100,000 of Assessed Value and a Tax Rate of \$X.XXXXXXXX per \$100 of

Assessed Value be levied upon the taxable property of the District and collected on the tax rolls of the County of Inyo.

Section 2: Said Tax Rate is based on an estimated net Fiscal Year Assessed Valuation of \$4,505,400,965 of property in the District, and will pay an estimated debt service amount of \$2,721,234 for Fiscal Year 2026-27 on the general obligation bonds to finance the construction and equipping of the expansion and renovation of the District's health facilities, as well as allow for a reserve with the objective of providing the taxpayers level assessments.

Section 3: The Board of Directors of the District does hereby agree to reimburse the County of Inyo for the expenses the county may reasonably incur as a result of the obligations created pursuant to such collection.

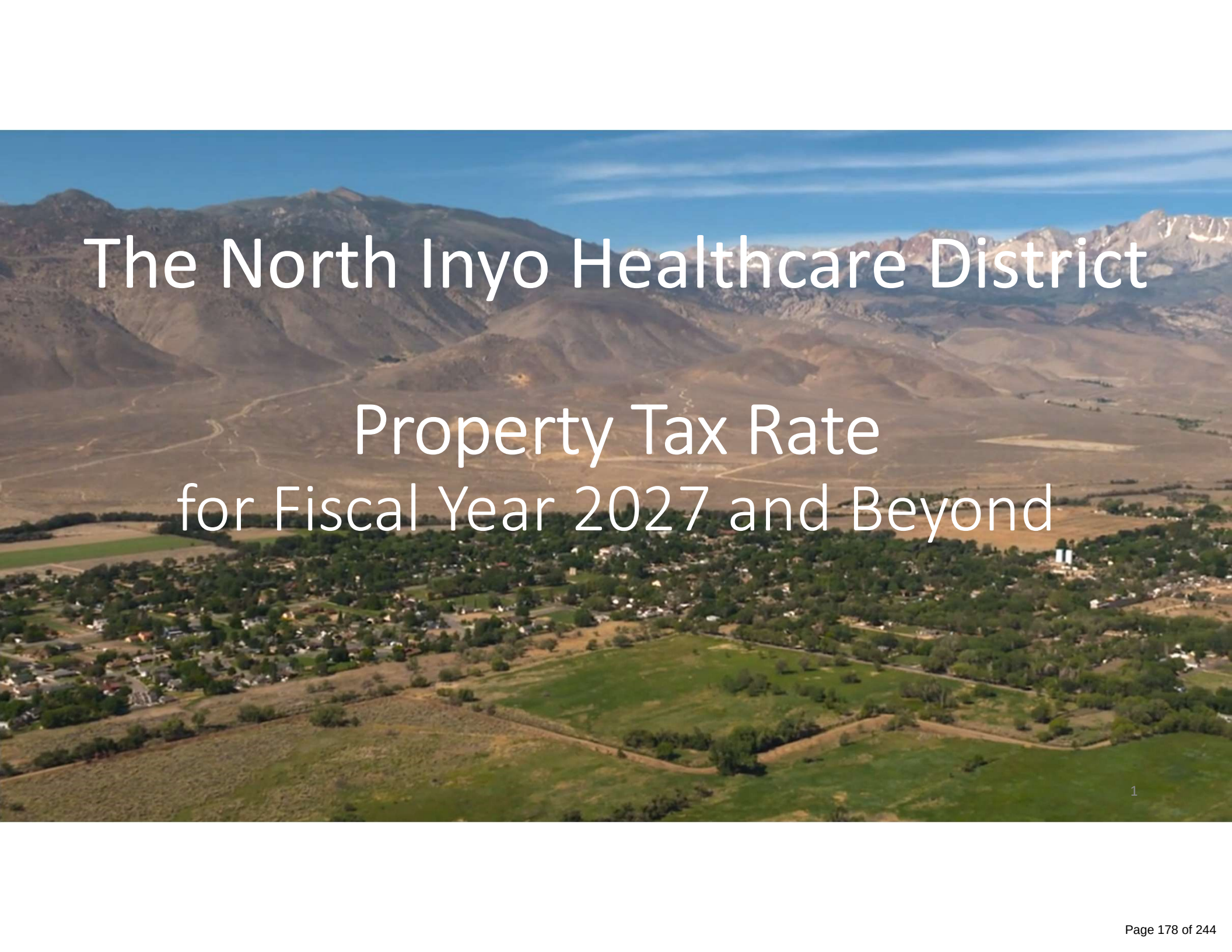
BE IT FURTHER RESOLVED that this Resolution be made a part of the minutes of this meeting; and this Resolution shall take effect immediately after its adoption on the date hereof.

PASSED, APPROVED, AND ADOPTED by the Northern Inyo Healthcare District this 15th day of July 2026 by the following vote:

AYES: _____
NOES: _____
ABSTAIN: _____
ABSENT: _____

By: _____
Melissa Best-Baker, Chair of the Board
Northern Inyo Healthcare District

ATTEST: _____
Clerk of the Board
Northern Inyo Healthcare District

An aerial photograph of a valley. In the foreground, there are green fields and a small town with many houses and trees. In the background, there are large, brown, rocky mountains under a blue sky with some light clouds. The text is overlaid on the image.

The North Inyo Healthcare District

Property Tax Rate for Fiscal Year 2027 and Beyond

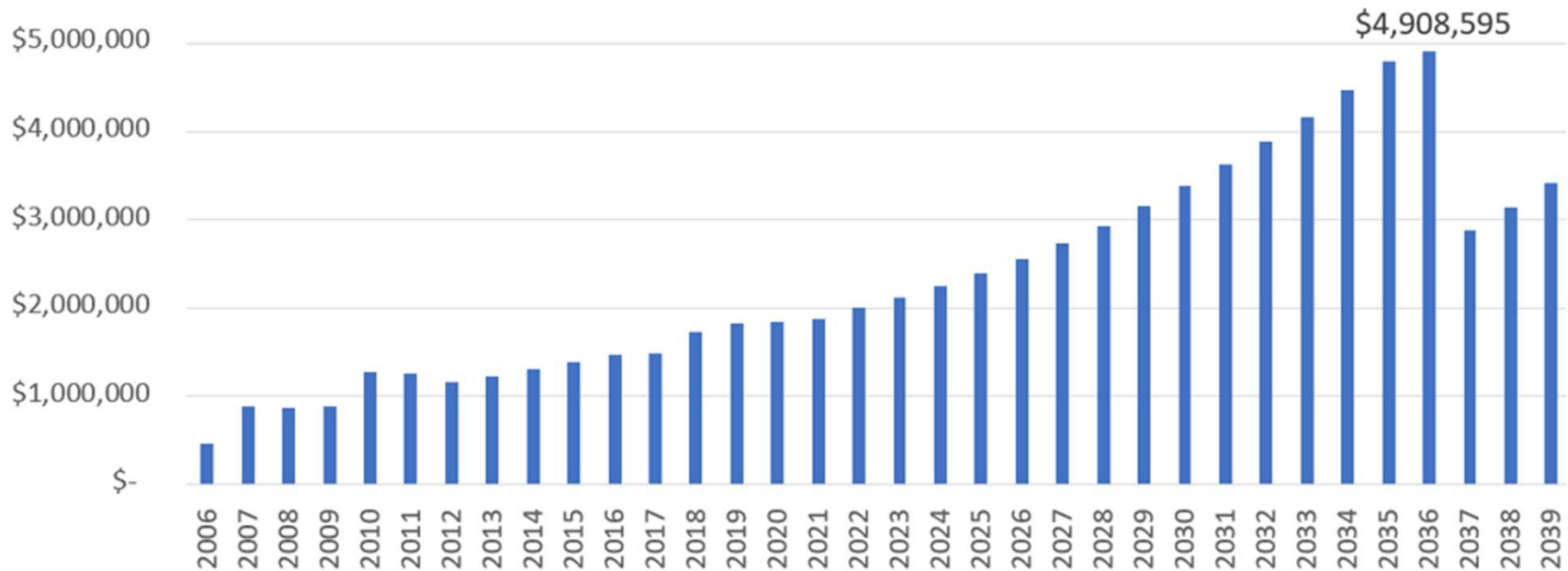
NIH General Obligation Bonds

- June 7, 2005 \$29.5 million GO Bonds approved by voters
- \$15,035,000 issued September 28, 2005
- \$14,464,947 issued April 21, 2009
- May 12, 2016 refunding bonds issued
- Proceeds funded the construction and equipping of the expansion and renovation of the District's health facilities

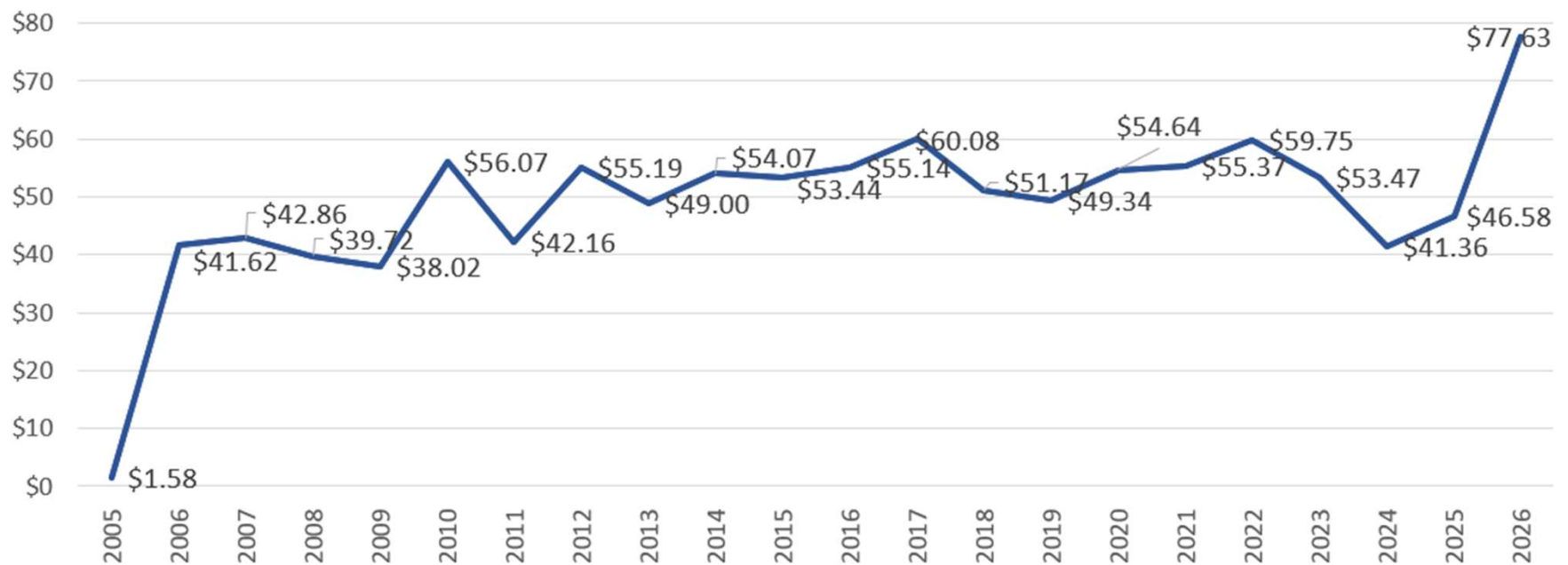


NIHD “is empowered and obligated to cause to be levied *ad valorem* taxes, **without limitation of rate or amount**, upon all property within the District subject to taxation by the District ... for the payment of interest on and principal of the Bonds ...”.

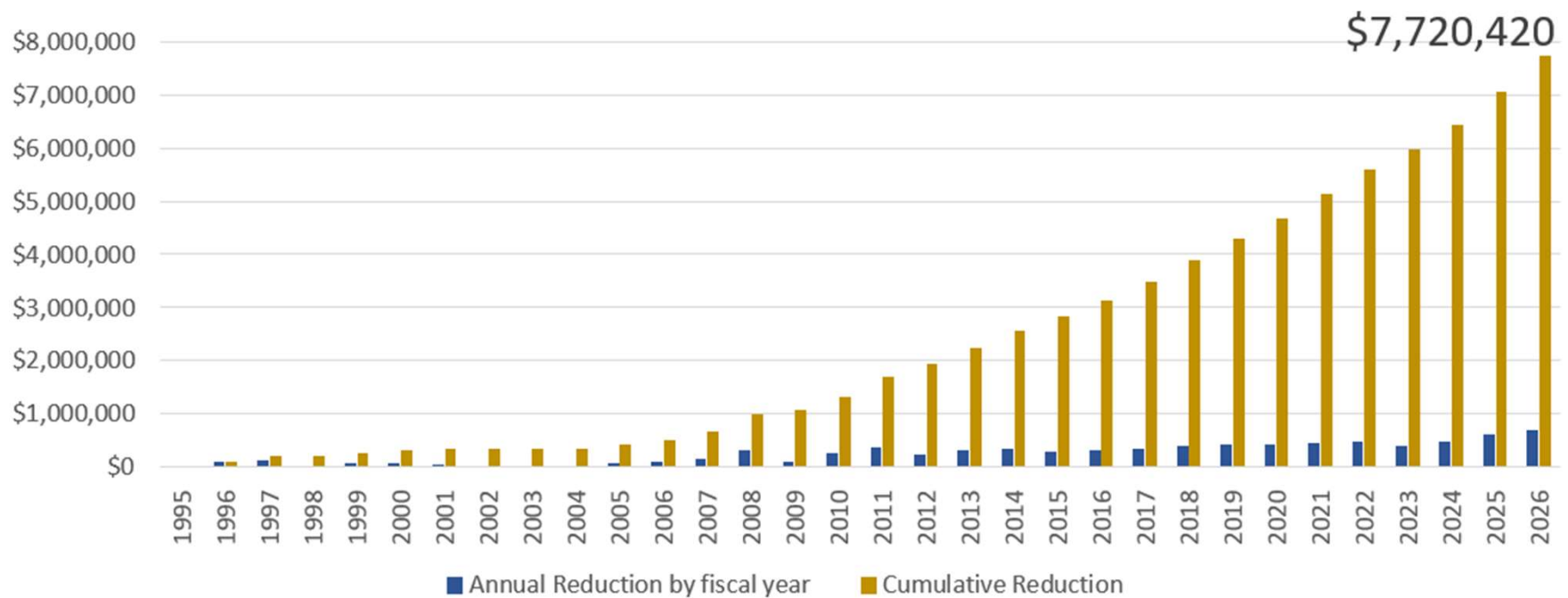
NIH GO Bond Debt Service *by Fiscal Year*



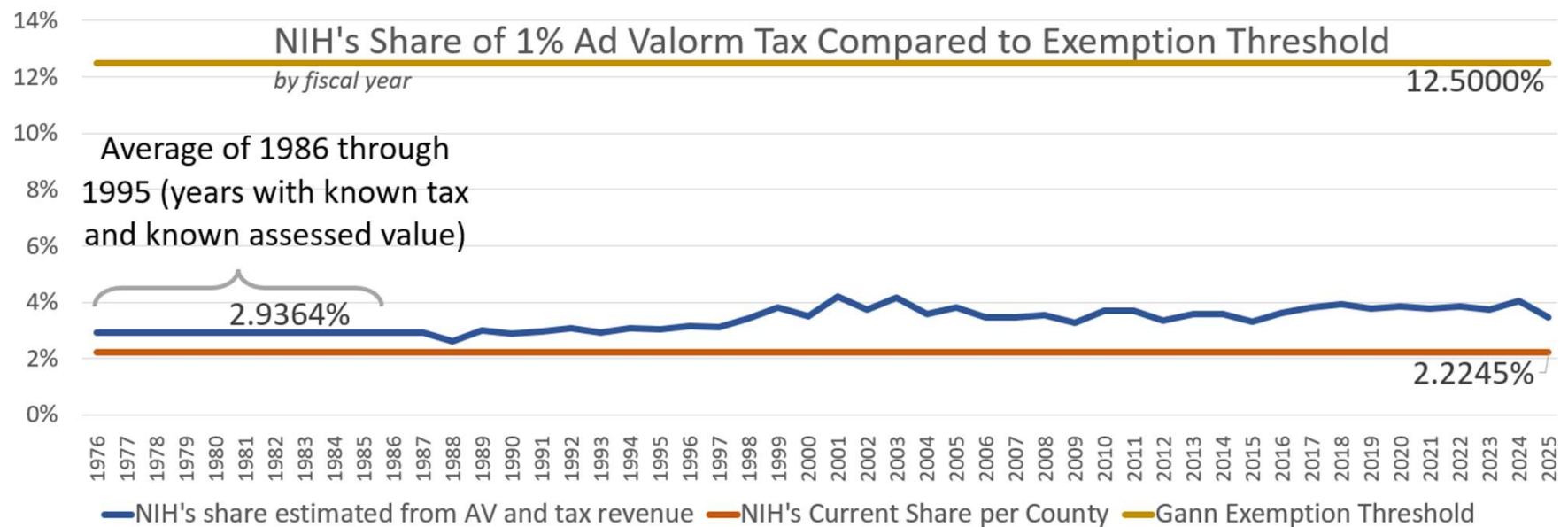
NIH GO Bond Tax Rate per \$100k of Assessed Value *by Fiscal Year*



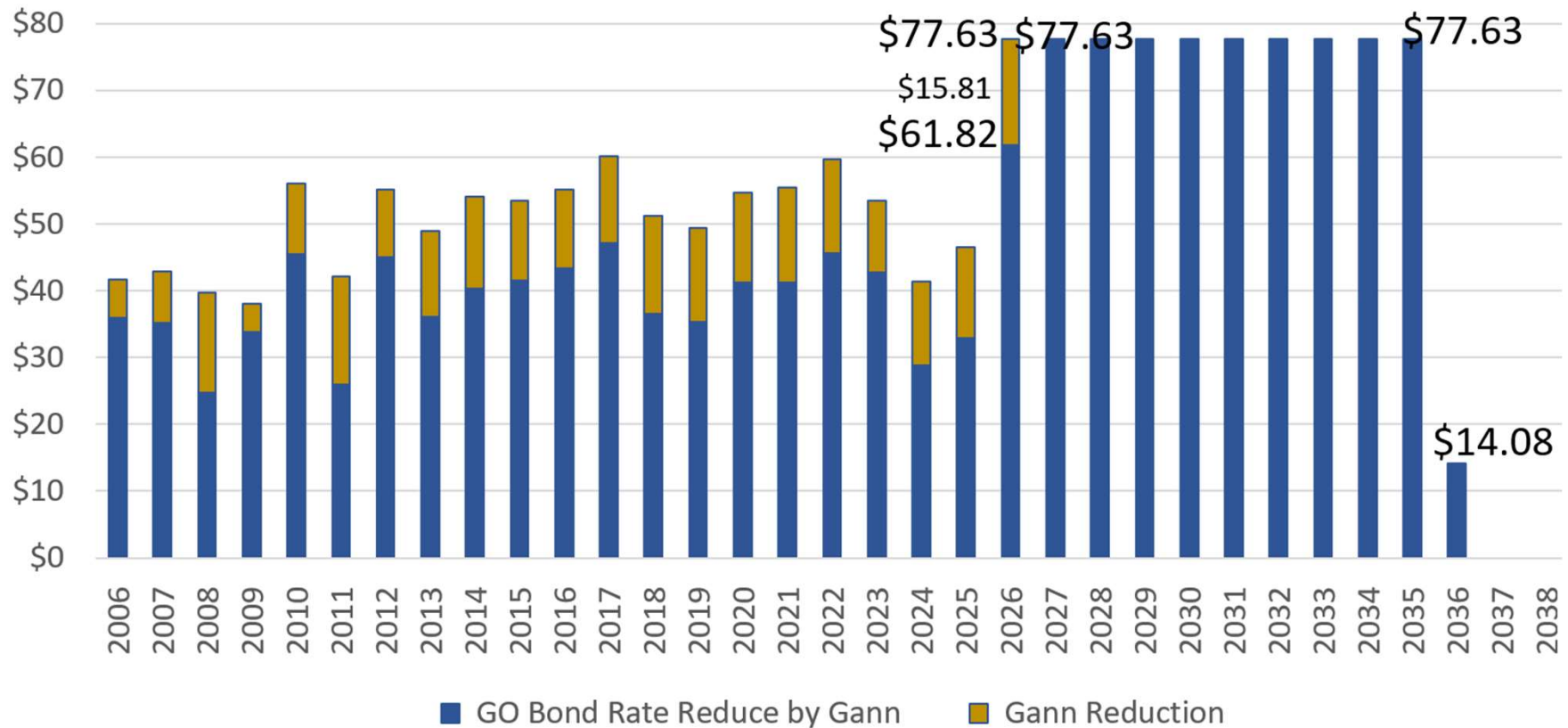
Property Tax Revenue Reduction from Gann Limit *by Fiscal Year*



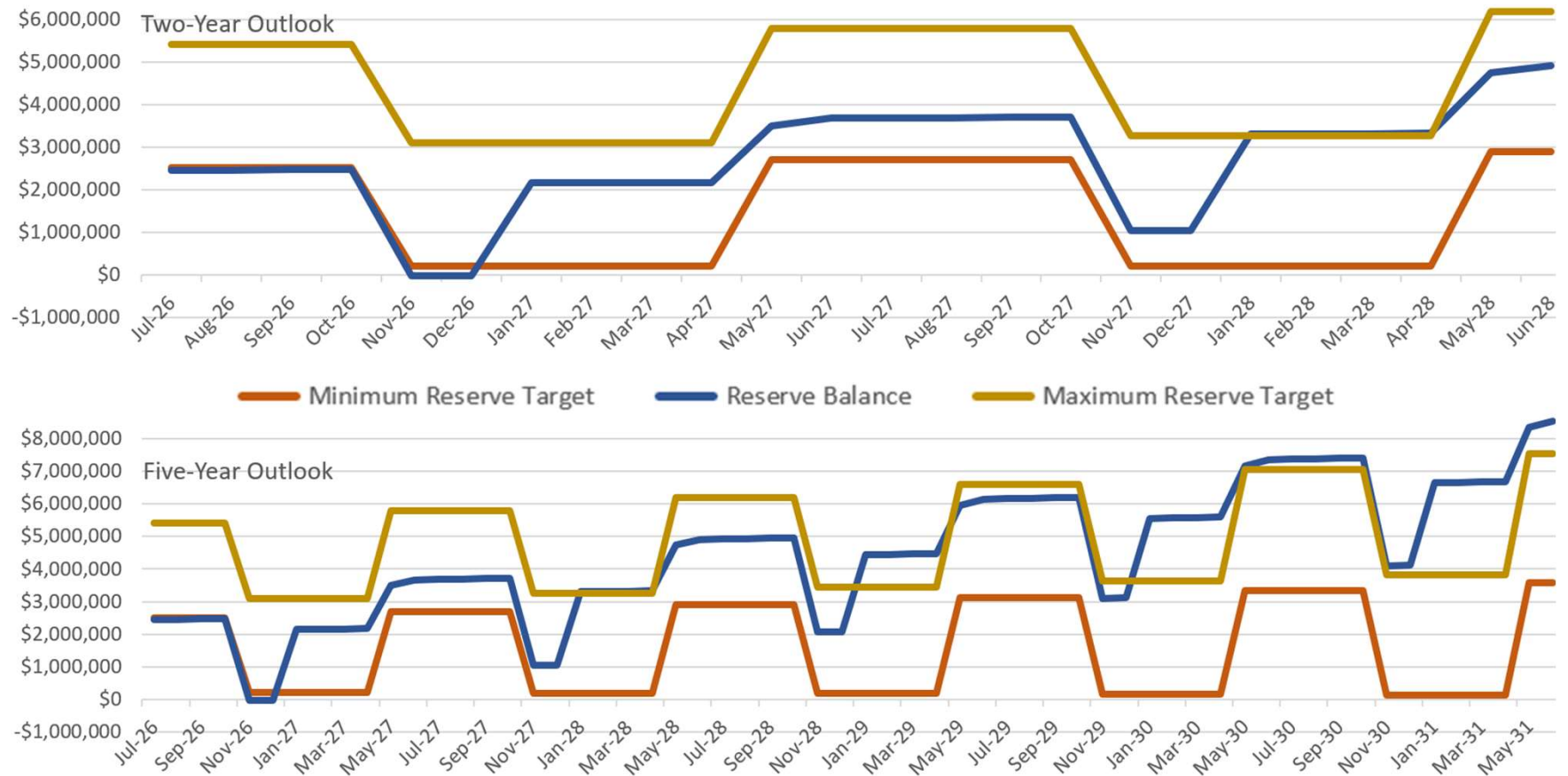
NIH is Exempt from the Gann Limit



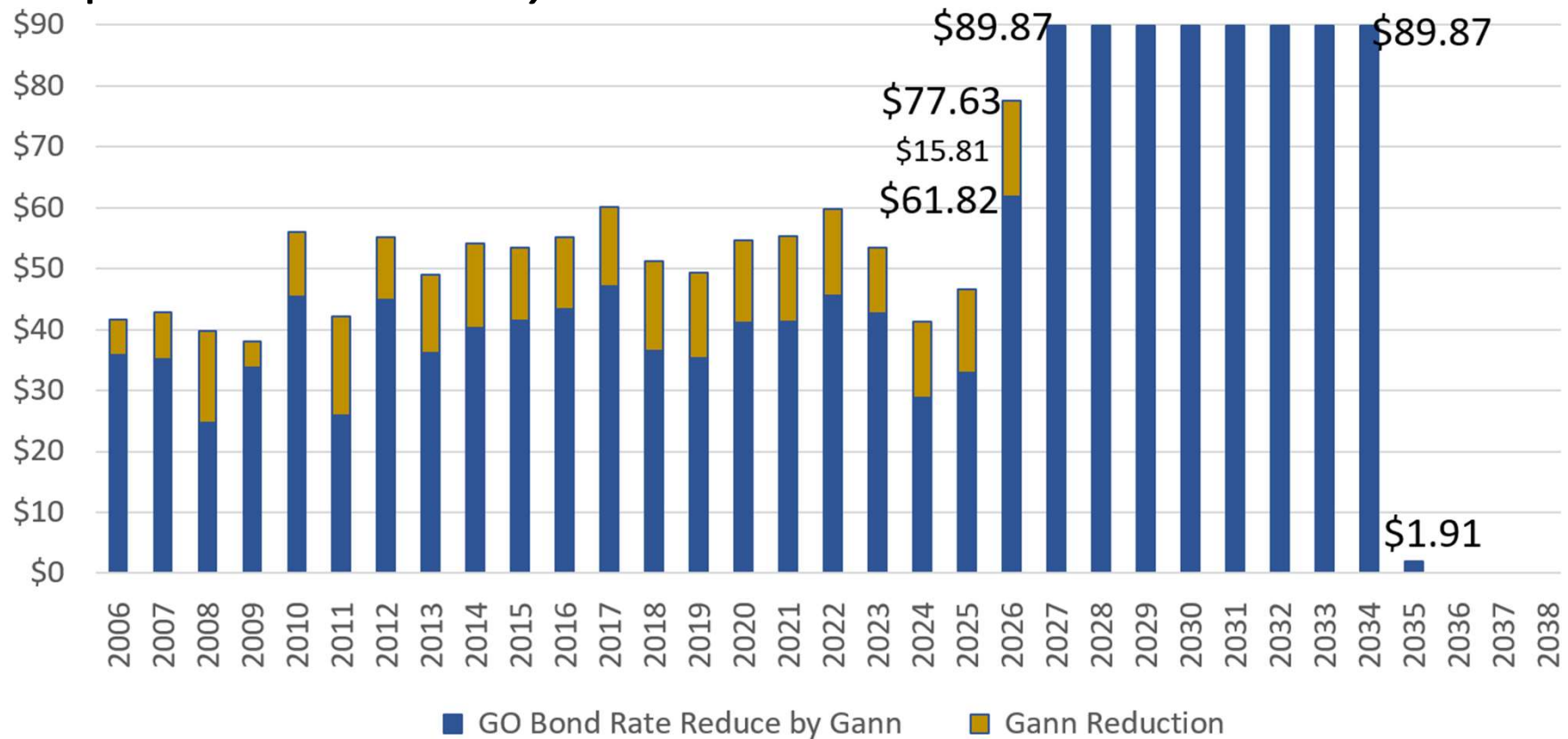
Option 1 – *Keep GO Bond Rate the Same*



Option 1 – Reserves

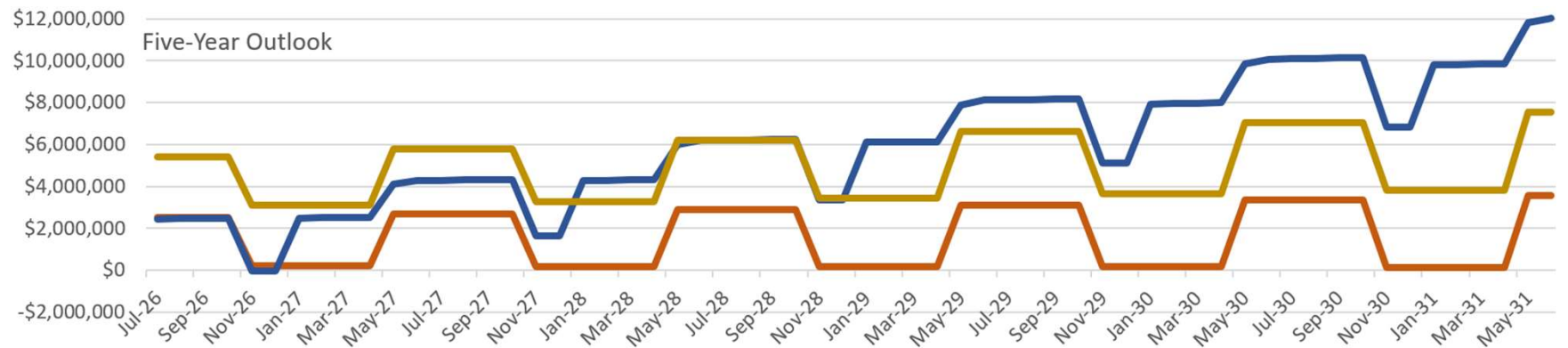
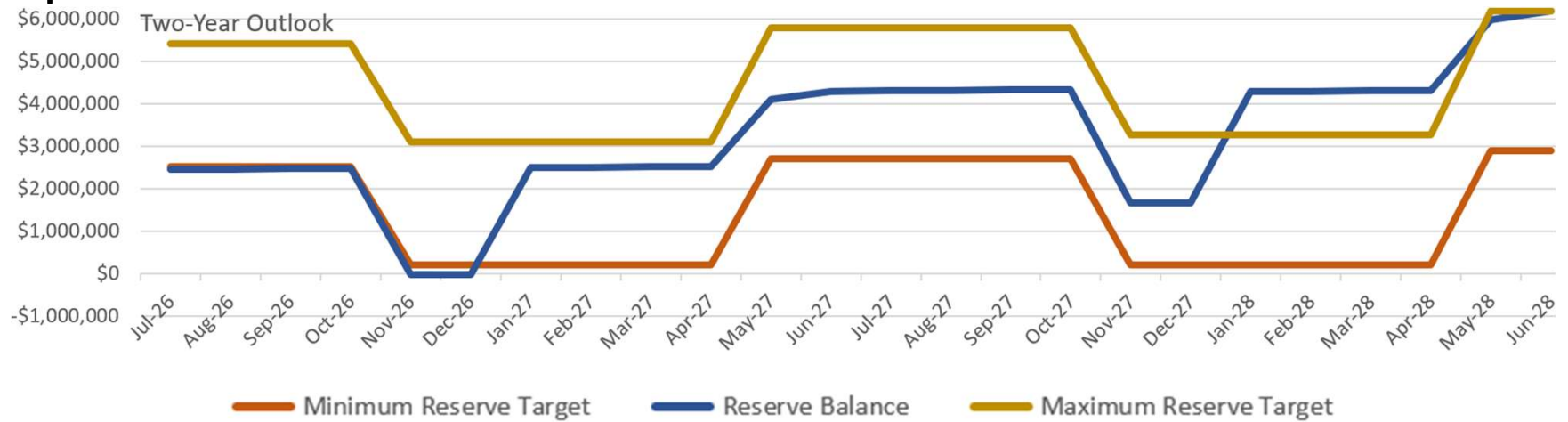


Option 2 – *Fully Fund Reserve in Two Years*

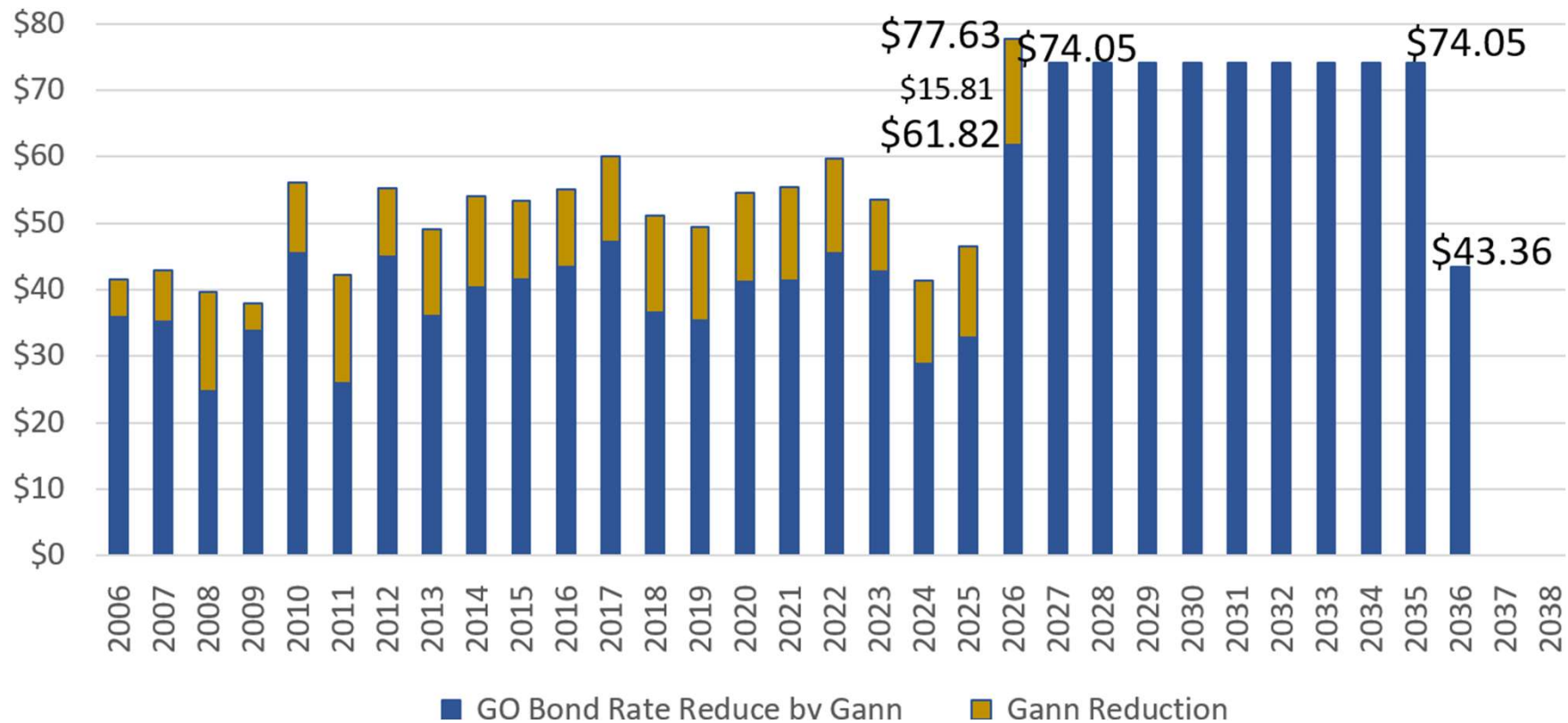


Increase of \$12.23 per \$100k of AV = 15.8%

Option 2 – Reserves

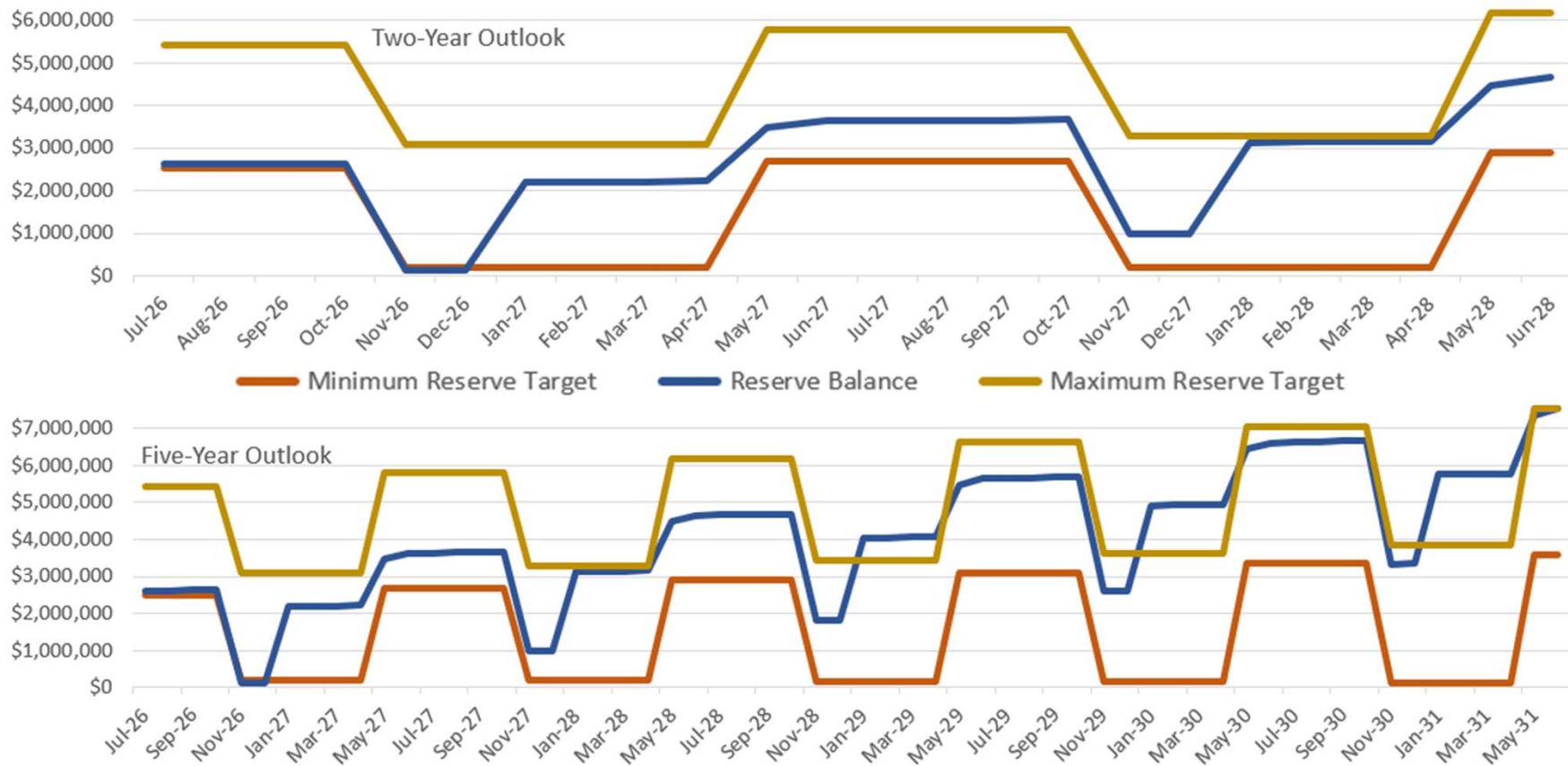


Option 3 – *Fully Fund Reserve in Five Years*



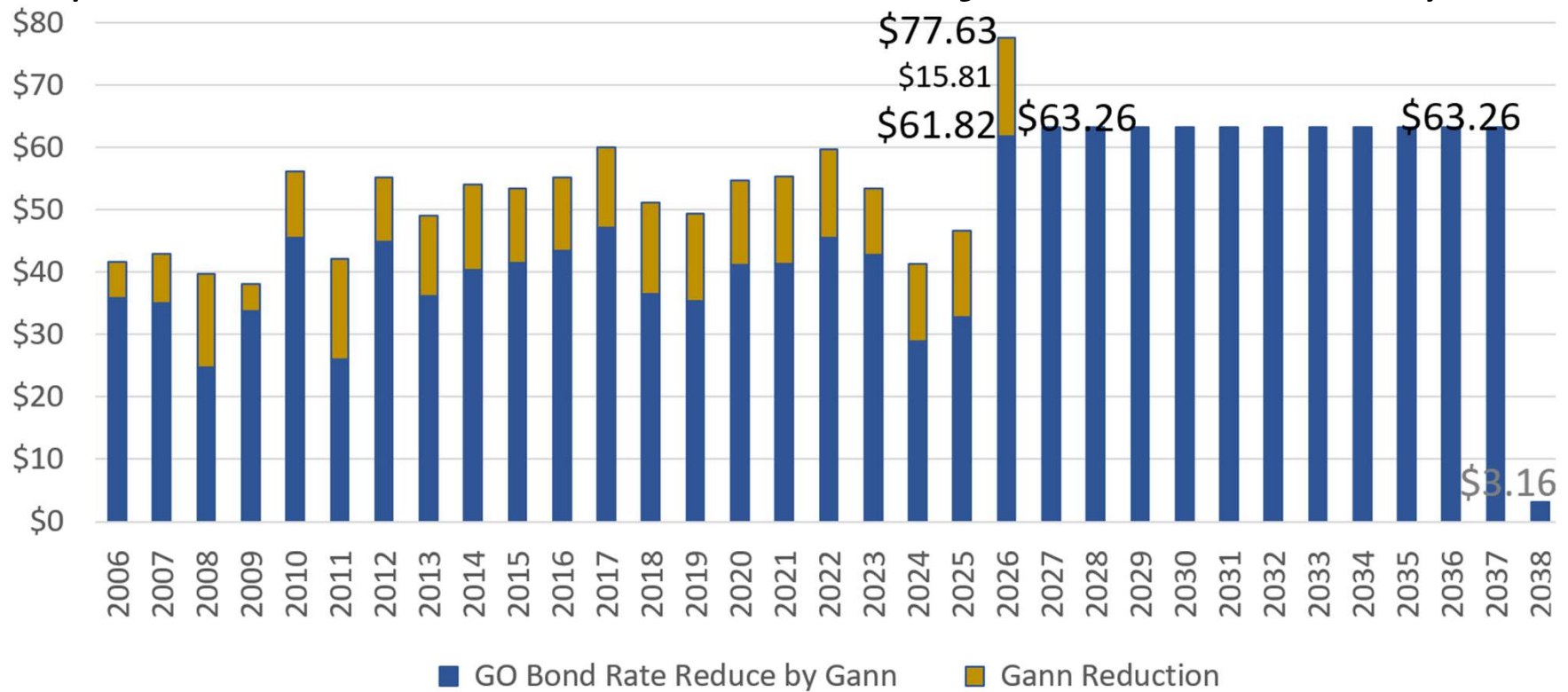
Decrease of \$3.58 per \$100k of AV = -4.6%

Option 3 – Reserves



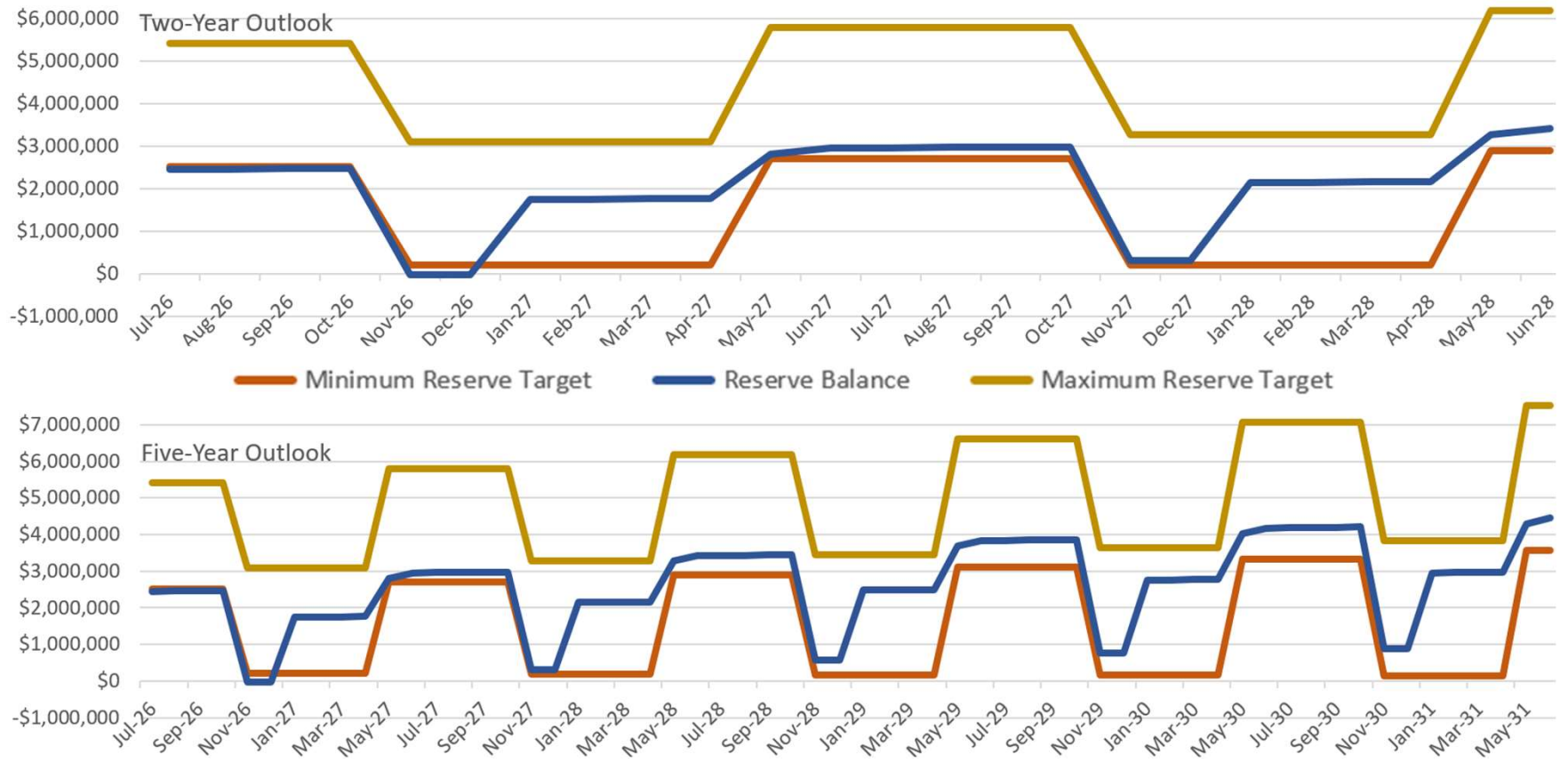
Option 4

Deplete Reserves to \$0 Ahead of Bond Maturity



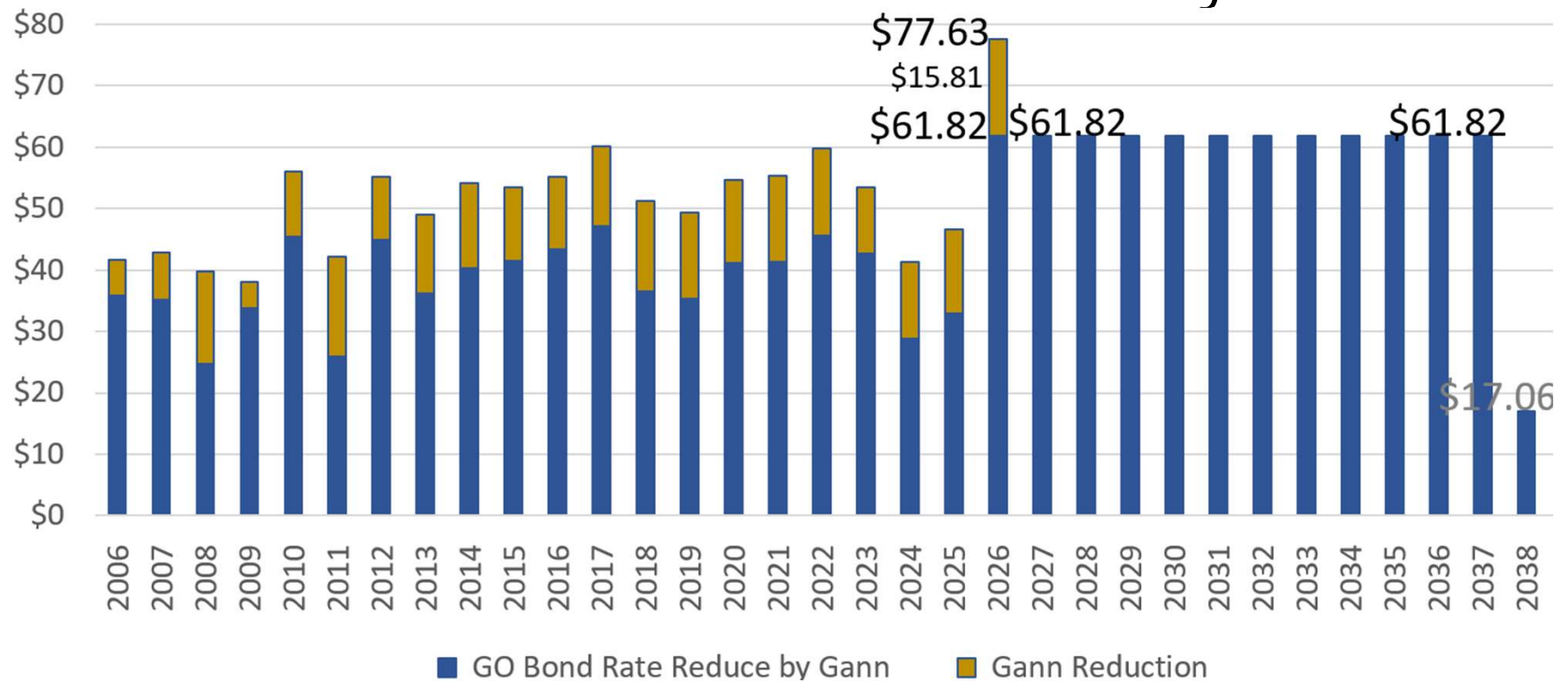
Decrease of \$14.37 per \$100k of AV = -18.5%

Option 4 – Reserves



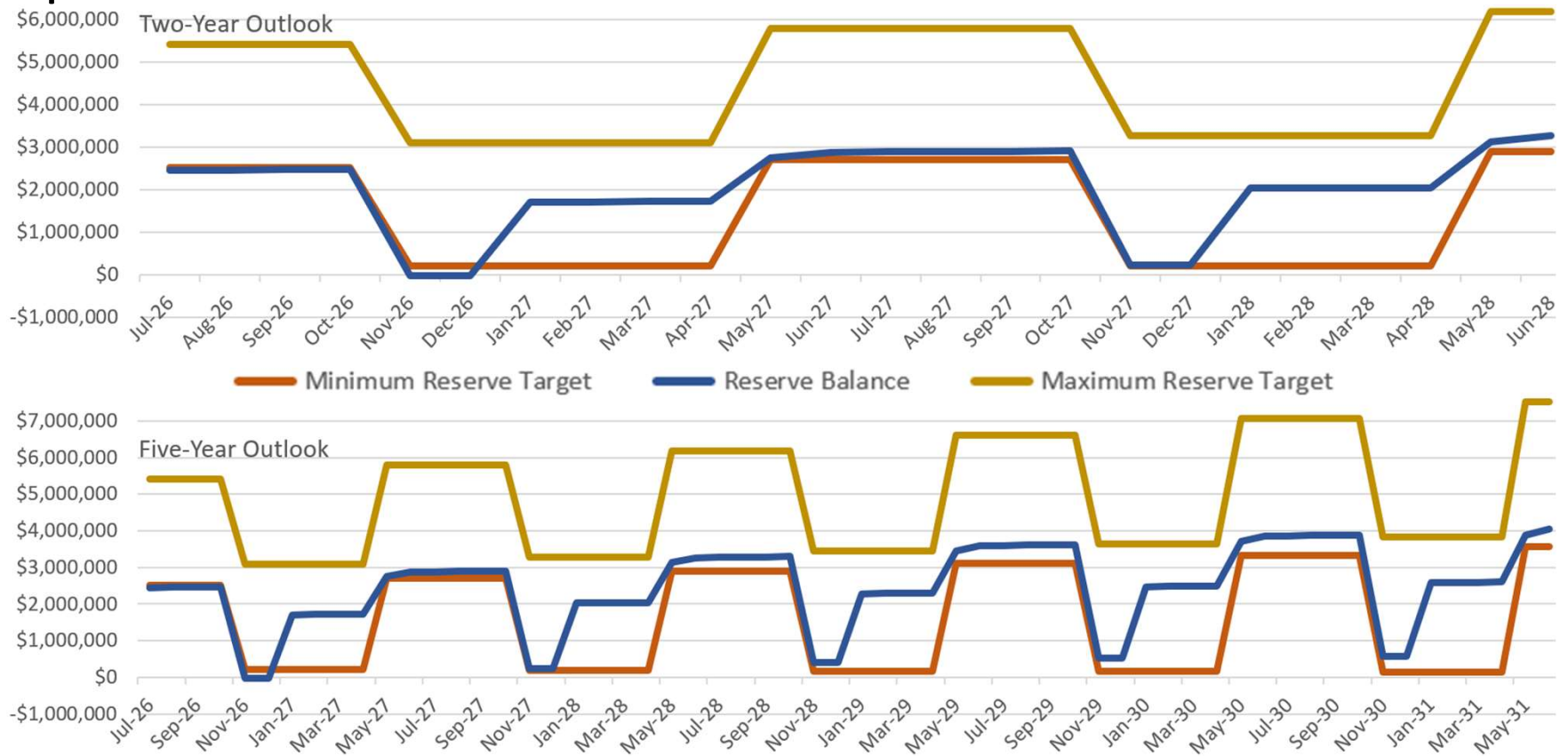
Option 5

Prior Year's Rate Less 2026 Gann Refund



Decrease of \$15.81 per \$100k of AV = -20.4%

Option 5 – Reserves



Rate Model Assumptions

Rate Model Assumptions		
June 30, 2026 reserve balance	\$	2,443,668
Fiscal Year 2026 property tax revenue	\$	3,720,414
Annual assessed value increase		3.90%
Annual investment earnings rate at June 30, 2026		3.51%
Monthly rate of decline in investment earnings rate		-0.83%
Distribution timing of annual property tax revenue:		
	January	56.19%
	May	39.65%
	June	4.16%





DATE: July 2026
TO: Board of Directors, Northern Inyo Healthcare District
FROM: Andrea Mossman, Chief Financial Officer
RE: Financial Summary and Operation Insights May 2026

Financial Performance

May closed with a net profit of **\$1.3 million, \$1.78 million favorable to budget**. Operating loss for the month was **\$1.49 million, \$777,000 better than budget**.

The favorable net income variance was primarily driven by stronger-than-budgeted orthopedic surgical volumes and higher non-operating income. Operating results were impacted by unbudgeted compensation adjustments and higher supply expenses associated with increased surgical activity.

Key Takeaway: May financial performance exceeded budget, driven by strong orthopedic volumes and higher supplemental income, partially offset by increased labor and supply costs.

Volume and Operational Metrics

Patient activity remained strong during May, with several key indicators performing at or above budget:

- Diagnostic Imaging volumes exceeded budget by **3%**.
- Surgeries exceeded budget by **19 cases (15%)**, driven by growth in orthopedic and urology procedures, partially offset by lower ophthalmology volumes following a physician retirement.

Areas below budget included:

- Admissions were **1 case below budget**.
- Inpatient days (excluding nursery) were **15 days below budget (6%)**.
- Average Daily Census was **6% below budget**.

- Emergency Department visits were **5% below budget**, consistent with lower county tourism activity.
- Rehabilitation visits were **3% below budget**.
- Rural Health Clinic visits were **13% below budget**.

Key Takeaway: Surgical growth, led by orthopedics and urology, continued to outperform expectations. However, inpatient volumes were below budget due to lower Emergency Department activity, and outpatient services—including clinic and rehabilitation visits—continued to lag.

Revenue and Deductions

Gross patient revenue exceeded budget by **\$2.6 million**, driven by stronger-than-expected surgical volumes and an unbudgeted rate increase.

Contractual deductions and allowances were **\$2.1 million above budget**, reflecting the higher gross revenue. As a result, net revenue yield was approximately **3% below budget** for the month.

Year-to-date, net patient revenue remains **\$4.1 million (4%) favorable to budget**.

Key Takeaway: Revenue performance remains strong, supported by increased patient volumes and improved reimbursement rates.

Expense Performance

Total operating expenses exceeded budget by **\$1.4 million (14%)** during May. Key drivers included:

- Salaries and wages were **11% above budget**, primarily due to compensation adjustments not included in the original budget.
- Supply expense exceeded budget by **\$367,000**, consistent with higher patient volumes.
- Professional fees exceeded budget by **\$252,000**, reflecting increased physician-related expenses and revenue cycle investments that continue to improve collections performance.

Key Takeaway: Labor, supply, and professional service costs continue to pressure operating performance despite strong revenue growth.

Labor and Workforce

Labor management remains a key operational priority.

- Contract labor expense exceeded budget by **\$123,172**.
- Contract labor full-time equivalents remained consistent with budget.
- Agency labor rates continued to be elevated, particularly within Labor & Delivery.
- Salaries, wages, and benefits represented **53% of total operating expenses**, compared to the organizational target of **50% or less**. Achieving this target represents approximately **\$4 million in annual savings** across wages, benefits, and contract labor.

Key Takeaway: The organization continues to reduce reliance on contract labor while maintaining staffing levels necessary to support patient care. Workforce optimization efforts remain a primary focus.

Cash and Liquidity

Liquidity and cash flow continued to strengthen during May.

- Days Cash on Hand was **114 days**, supported in part by a one-time Employee Retention Credit (ERC) receipt of approximately **\$8.0 million**.
- Unrestricted cash totaled **\$37.8 million**, an increase of **\$10 million** compared to the prior year.
- Revenue cycle performance continued to improve:
 - o Accounts receivable days decreased by **18 days year over year**.
 - o Bad debt and write-offs were **\$671,548 below budget**.
 - o Accounts receivable balances greater than 90 days declined by **\$3.9 million year over year**.

Key Takeaway: Liquidity remains strong. Continued improvements in revenue cycle performance are accelerating cash collections and strengthening the organization's financial position.

Overall Assessment

Operational performance remained strong during May, led by continued growth in orthopedic and urology surgical volumes. Year-to-date net revenue remains above budget, while revenue cycle improvements continue to strengthen liquidity and cash flow. Although labor and operating cost pressures persist, the organization continues to make meaningful progress in workforce stabilization and financial performance.

Strategic Focus / Action Plan

- Continue growth in orthopedic, urology, and general surgery volumes.
 - Improve operating room and clinic scheduling efficiency.
 - Advance revenue cycle optimization through improved denials management, coding, and collections.
 - Maintain focus on labor productivity, workforce optimization, and cost control.
-

Overall Summary

May results exceeded budget, driven by continued strength in orthopedic surgical volumes and favorable non-operating income. While labor and operating expense pressures remain, improving cash flow, revenue cycle performance, and sustained surgical growth continue to strengthen the organization's overall financial position.

Northern Inyo Healthcare District
May 2026 – Financial Summary

	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
** Variances are B / (W)														
Net Income (Loss)	1,318,651	(457,012)	1,775,663	(389%)	(2,134,682)	3,453,333	162%	5,750,268	4,496,581	1,253,687	(28%)	2,830,496	2,919,772	103%
Operating Income (Loss)	(1,494,921)	(717,933)	(776,987)	108%	(2,485,229)	990,309	40%	(12,819,367)	(8,549,750)	(4,269,617)	(50%)	(9,765,614)	(3,053,753)	31%
EBIDA (Loss)	1,819,274	(39,858)	1,859,133	(4,664%)	(1,725,518)	3,544,792	205%	10,892,894	9,085,274	1,807,621	(20%)	7,427,178	3,465,716	47%
IP Gross Revenue	4,196,525	3,716,213	480,312	13%	3,371,624	824,901	24%	44,874,287	40,159,075	4,715,212	12%	40,773,821	4,100,466	10%
OP Gross Revenue	16,694,284	14,695,389	1,998,894	14%	13,103,211	3,591,072	27%	163,531,666	158,533,987	4,997,679	3%	152,515,200	11,016,466	7%
Clinic Gross Revenue	1,904,971	1,784,825	120,145	7%	1,810,472	94,499	5%	21,661,067	19,351,390	2,309,678	12%	19,422,853	2,238,214	12%
Total Gross Revenue	22,795,779	20,196,427	2,599,352	13%	18,285,307	4,510,472	25%	230,067,020	218,044,452	12,022,568	6%	212,711,874	17,355,146	8%
Net Patient Revenue	9,818,224	9,222,576	595,649	6%	7,772,831	2,045,393	26%	103,585,720	99,456,055	4,129,665	4%	96,158,009	7,427,711	8%
<i>Cash Net Revenue % of Gross</i>	43%	46%	(3%)	(6%)	43%	1%	1%	45%	46%	(1%)	(1%)	45%	(0%)	(0%)
Admits (excl. Nursery)	86	87	(1)	(1%)	87	(1)	(1%)	808	784	24	3%	784	24	3%
IP Days	271	296	(24)	(8%)	296	(24)	(8%)	2,664	2,688	(24)	(1%)	2,688	(24)	(1%)
IP Days (excl. Nursery)	243	258	(15)	(6%)	258	(15)	(6%)	2,301	2,318	(17)	(1%)	2,318	(17)	(1%)
Average Daily Census	7.8	8.3	(0.5)	(6%)	8.3	(0.5)	(6%)	6.9	6.9	(0.1)	(1%)	6.9	(0.1)	(1%)
ALOS	2.8	3.0	(0.1)	(5%)	3.0	(0.1)	(5%)	2.8	3.0	(0.1)	(4%)	3.0	(0.1)	(4%)
Deliveries	13	19	(6)	(32%)	19	(6)	(32%)	178	187	(9)	(5%)	187	(9)	(5%)
OP Visits	4,092	4,178	(86)	(2%)	4,178	(86)	(2%)	44,843	43,943	900	2%	43,943	900	2%
Rural Health Clinic Visits	2,243	2,439	(196)	(8%)	2,439	(196)	(8%)	25,486	25,561	(75)	(0%)	25,561	(75)	(0%)
Rural Health Women Visits	499	566	(67)	(12%)	566	(67)	(12%)	5,942	5,777	165	3%	5,777	165	3%
Rural Health Behavioral Visits	102	257	(155)	(60%)	257	(155)	(60%)	1,252	2,293	(1,041)	(45%)	2,293	(1,041)	(45%)
Total RHC Visits	2,844	3,262	(418)	(13%)	3,262	(418)	(13%)	32,680	33,631	(951)	(3%)	33,631	(951)	(3%)
Bronco Clinic Visits	63	20	43	215%	20	43	215%	430	394	36	9%	394	36	9%
Internal Medicine Clinic Visits	-	-	-	-%	-	-	-%	-	-	-	-%	-	-	-%
Orthopedic Clinic Visits	301	300	1	0%	300	1	0%	3,629	3,800	(171)	(5%)	3,800	(171)	(5%)
Pediatric Clinic Visits	536	478	58	12%	478	58	12%	6,361	6,455	(94)	(1%)	6,455	(94)	(1%)
Specialty Clinic Visits	630	668	(38)	(6%)	668	(38)	(6%)	7,398	6,137	1,261	21%	6,137	1,261	21%
Surgery Clinic Visits	118	132	(14)	(11%)	132	(14)	(11%)	1,595	1,691	(96)	(6%)	1,691	(96)	(6%)
Virtual Care Clinic Visits	-	51	(51)	(100%)	51	(51)	(100%)	309	627	(318)	(51%)	627	(318)	(51%)
Total NIA Clinic Visits	1,648	1,649	(1)	(0%)	1,649	(1)	(0%)	19,722	19,104	618	3%	19,104	618	3%
IP Surgeries	14	10	4	40%	10	4	40%	129	126	3	2%	126	3	2%
OP Surgeries	128	113	15	13%	113	15	13%	1,379	1,407	(28)	(2%)	1,407	(28)	(2%)
Total Surgeries	142	123	19	15%	123	19	15%	1,508	1,533	(25)	(2%)	1,533	(25)	(2%)
Cardiology	2	3	(1)	(33%)	3	(1)	(33%)	28	7	21	300%	7	21	300%
General	70	71	(1)	(1%)	71	(1)	(1%)	866	778	88	11%	778	88	11%
Gynecology & Obstetrics	11	10	1	10%	10	1	10%	120	128	(8)	(6%)	128	(8)	(6%)
Ophthalmology	-	15	(15)	(100%)	15	(15)	(100%)	68	265	(197)	(74%)	265	(197)	(74%)
Orthopedic	40	9	31	344%	9	31	344%	260	205	55	27%	205	55	27%
Pediatric	-	-	-	-%	-	-	-%	-	1	(1)	(100%)	1	(1)	(100%)
Plastics	-	-	-	-%	-	-	-%	2	2	-	-%	2	-	-%
Podiatry	-	-	-	-%	-	-	-%	3	6	(3)	(50%)	6	(3)	(50%)
Urology	19	15	4	27%	15	4	27%	161	138	23	17%	138	23	17%
Diagnostic Image Exams	2,286	2,210	76	3%	2,210	76	3%	24,514	23,082	1,432	6%	23,082	1,432	6%
Emergency Visits	857	899	(42)	(5%)	899	(42)	(5%)	9,289	9,330	(41)	(0%)	9,330	(41)	(0%)
ED Admits	59	58	1	2%	58	1	2%	501	471	30	6%	471	30	6%
ED Admits % of ED Visits	7%	6%	0%	7%	6%	0%	7%	5%	5%	0%	7%	5%	0%	7%
Rehab Visits	843	865	(22)	(3%)	865	(22)	(3%)	8,941	9,445	(504)	(5%)	9,445	(504)	(5%)
OP Infusion/Wound Care Visits	725	686	39	6%	686	39	6%	7,299	6,331	968	15%	6,331	968	15%
Observation Hours	1,473	1,309	164	13%	1,309	164	13%	13,752	16,272	(2,520)	(15%)	16,272	(2,520)	(15%)

Northern Inyo Healthcare District
May 2026 – Financial Summary

** Variances are B / (W)

PAYOR MIX (Patient Days)

	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
Blue Cross	22.3%	17.5%	4.8%	27.5%	17.5%	4.8%	27.5%	23.0%	23.3%	(0.4%)	(1.6%)	23.3%	(0.4%)	(1.6%)
Commercial	1.5%	6.3%	(4.8%)	(76.2%)	6.3%	(4.8%)	(76.2%)	6.0%	7.5%	(1.5%)	(19.7%)	7.5%	(1.5%)	(19.7%)
Medicaid	16.6%	19.5%	(2.9%)	(14.9%)	19.5%	(2.9%)	(14.9%)	21.6%	26.5%	(4.9%)	(18.5%)	26.5%	(4.9%)	(18.5%)
Medicare	57.9%	54.7%	3.1%	5.7%	54.7%	3.1%	5.7%	47.2%	40.2%	7.0%	17.4%	40.2%	7.0%	17.4%
Self-pay	1.7%	2.0%	(0.3%)	(13.9%)	2.0%	(0.3%)	(13.9%)	2.0%	2.0%	0.0%	0.2%	2.0%	0.0%	0.2%
Worker's Comp	-%	-%	-%	-%	-%	-%	-%	0.1%	0.3%	(0.2%)	(62.9%)	0.3%	(0.2%)	(62.9%)
Other	-%	-%	-%	-%	-%	-%	-%	-%	0.0%	(0.0%)	(100.0%)	0.0%	(0.0%)	(100.0%)

PAYOR MIX (Gross Revenue)

Blue Cross	26.2%	26.1%	0.0%	0.0%	26.1%	0.0%	0.0%	28.1%	26.7%	1.4%	5.4%	26.7%	1.4%	5.4%
Commercial	7.8%	6.6%	1.2%	18.9%	6.6%	1.2%	18.9%	6.6%	7.0%	(0.4%)	(5.7%)	7.0%	(0.4%)	(5.7%)
Medicaid	16.9%	17.9%	(0.9%)	(5.2%)	17.9%	(0.9%)	(5.2%)	17.6%	19.3%	(1.6%)	(8.5%)	19.3%	(1.6%)	(8.5%)
Medicare	46.2%	46.3%	(0.1%)	(0.3%)	46.3%	(0.1%)	(0.3%)	44.8%	43.6%	1.2%	2.8%	43.6%	1.2%	2.8%
Self-pay	2.2%	2.5%	(0.3%)	(12.0%)	2.5%	(0.3%)	(12.0%)	1.9%	2.3%	(0.4%)	(15.9%)	2.3%	(0.4%)	(15.9%)
Worker's Comp	0.6%	0.6%	0.0%	5.7%	0.6%	0.0%	5.7%	0.8%	1.0%	(0.3%)	(24.8%)	1.0%	(0.3%)	(24.8%)
Other	0.2%	0.1%	0.1%	97.2%	0.1%	0.1%	97.2%	0.2%	0.2%	0.0%	15.3%	0.2%	0.0%	15.3%

DEDUCTIONS

Contract Adjust	(12,797,977)	(9,943,164)	(2,854,813)	29%	(7,499,521)	(5,298,457)	71%	(119,591,245)	(107,450,320)	(12,140,925)	11%	(101,150,225)	(18,441,020)	18%
Bad Debt	63,117	(119,730)	182,848	(153%)	(2,837,626)	2,900,743	(102%)	(3,686,110)	(1,293,860)	(2,392,251)	185%	(6,971,246)	3,285,136	(47%)
Write-off	(242,695)	(731,396)	488,701	(67%)	(177,633)	(65,062)	37%	(4,513,674)	(7,903,791)	3,390,116	(43%)	(8,286,515)	3,772,840	(46%)

CENSUS

Patient Days	243	258	(15)	(6%)	258	(15)	(6%)	2,301	2,318	(17)	(1%)	2,318	(17)	(1%)
Adjusted ADC	43	39	4	10%	39	4	10%	35	36	(1)	(2%)	36	(1)	(2%)
Adjusted Days	1,318	1,399	(81)	(6%)	1,399	(81)	(6%)	11,796	12,092	(296)	(2%)	12,092	(296)	(2%)
Employed FTE	367.3	375.4	(8.1)	(2%)	375.4	(8.1)	(2%)	378.6	369.7	8.8	2%	369.7	8.8	2%
Contract Labor FTE	19.8	19.7	0.1	0%	19.7	0.1	0%	19.7	24.2	(4.5)	(19%)	24.2	(4.5)	(19%)
Total Paid FTE	387.1	395.1	(8.1)	(2%)	395.1	(8.1)	(2%)	398.2	393.9	4.3	1%	393.9	4.3	1%
EPOB (Employee per Occupied Bed)	1.6	1.5	0.1	4%	1.5	0.1	4%	1.9	1.8	0.0	2%	1.8	0.0	2%
EPOC (Employee per Occupied Case)	0.3	0.3	(0.0)	(11%)	0.3	(0.0)	(11%)	0.0	0.0	0.0	3%	0.0	0.0	3%
Adjusted EPOB	8.7	8.3	0.4	4%	8.3	0.4	4%	9.6	9.6	0.0	0%	9.6	0.0	0%
Adjusted EPOC	1.6	1.8	(0.2)	(11%)	1.8	(0.2)	(11%)	0.2	0.2	0.0	1%	0.2	0.0	1%

SALARIES

Per Adjust Bed Day	2,796	2,456	340	14%	2,573	223	9%	3,450	3,050	400	13%	3,014	436	14%
Total Salaries	3,684,604	3,435,715	248,890	7%	3,599,495	85,110	2%	40,697,331	36,882,341	3,814,990	10%	36,447,982	4,249,348	12%
Average Hourly Rate	56.63	51.66	4.97	10%	54.12	2.51	5%	56.16	52.11	4.05	8%	51.49	4.67	9%
Employed Paid FTEs	367.3	375.4	(8.1)	383.6	375.4	(8.1)	(2%)	378.6	369.7	8.8	2%	369.7	8.8	2%

BENEFITS

Per Adjust Bed Day	1,397	1,099	298	27%	826	571	69%	1,387	1,373	14	1%	1,342	45	3%
Total Benefits	1,840,959	1,536,859	304,100	20%	1,155,616	685,343	59%	16,359,058	16,598,288	(239,230)	(1%)	16,226,643	132,415	1%
Benefits % of Wages	50%	45%	5%	12%	32%	18%	56%	40%	45%	(5%)	(11%)	45%	(4%)	(10%)
Pension Expense	389,895	393,976	(4,081)	(1%)	407,004	(17,110)	(4%)	3,964,817	4,258,921	(294,104)	(7%)	4,343,550	(378,733)	(9%)
MDV Expense	1,019,787	782,153	237,634	30%	444,654	575,134	129%	8,705,705	8,452,300	253,406	3%	8,279,643	426,062	5%
Taxes, PTO accrued, Other	431,278	360,730	70,547	20%	303,958	127,319	42%	3,688,536	3,887,068	(198,532)	(5%)	3,603,450	85,086	2%
Salaries, Wages & Benefits	5,525,563	4,972,574	552,990	11%	4,755,111	770,452	16%	57,056,389	53,480,629	3,575,760	7%	52,674,626	4,381,764	8%
SWB/APD	4,193	3,555	638	18%	3,400	793	23%	4,837	4,423	414	9%	4,356	481	11%
SWB % of Total Expenses	49%	50%	(1%)	(2%)	46%	2%	5%	49%	50%	(1%)	(1%)	50%	(1%)	(1%)

Northern Inyo Healthcare District
May 2026 – Financial Summary

** Variances are B / (W)

PROFESSIONAL FEES

Per Adjust Bed Day
Total Physician Fee
Total Contract Labor
Total Other Pro-Fees
Total Professional Fees
Contract AHR
Contract Paid FTEs
Physician Fee per Adjust Bed Day

PHARMACY

Per Adjust Bed Day
Total Rx Expense

MEDICAL SUPPLIES

Per Adjust Bed Day
Total Medical Supplies

EHR SYSTEM

Per Adjust Bed Day
Total EHR Expense

OTHER EXPENSE

Per Adjust Bed Day
Total Other

DEPRECIATION AND AMORTIZATION

Per Adjust Bed Day
Total Depreciation and Amortization

TOTAL EXPENSES

Per Adjust Bed Day
Per Calendar Day

Current Month				Prior MTD			Year to Date				Prior YTD		
Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
2,274	1,963	311	16%	2,461	(187)	(8%)	2,761	2,510	251	10%	2,418	343	14%
1,802,579	1,721,844	80,735	5%	1,878,965	(76,387)	(4%)	19,844,038	18,810,152	1,033,886	5%	17,728,913	2,115,125	12%
484,968	361,796	123,172	34%	392,345	92,623	24%	3,939,700	4,287,356	(347,656)	(8%)	4,831,945	(892,245)	(18%)
709,167	661,383	47,784	7%	1,170,777	(461,611)	(39%)	8,782,455	7,249,193	1,533,262	21%	6,674,439	2,108,016	32%
2,996,714	2,745,023	251,690	9%	3,442,088	(445,374)	(13%)	32,566,193	30,346,701	2,219,492	7%	29,235,297	3,330,896	11%
138.58	103.72	34.86	34%	112.48	26.10	23%	104.58	92.56	12.02	13%	104.32	0.26	0%
19.8	19.7	0.1	0%	19.7	0.1	0%	19.7	24.2	(4.5)	(19%)	24.2	(4.5)	(19%)
1,368	1,231	137	11%	1,343	24	2%	1,682	1,556	127	8%	1,466	216	15%
369	323	46	14%	237	132	55%	412	404	8	2%	349	63	18%
485,963	451,577	34,386	8%	331,813	154,150	46%	4,857,323	4,879,943	(22,620)	(0%)	4,216,124	641,200	15%
589	316	272	86%	177	412	232%	503	395	108	27%	395	108	27%
775,662	442,142	333,520	75%	247,645	528,017	213%	5,938,116	4,776,902	1,161,214	24%	4,780,159	1,157,957	24%
24	23	1	4%	35	(11)	(32%)	34	29	4	15%	32	1	5%
31,361	32,115	(754)	(2%)	49,037	(17,676)	(36%)	395,888	353,262	42,626	12%	387,726	8,162	2%
757	629	128	20%	732	25	3%	886	792	94	12%	830	56	7%
997,259	879,924	117,334	13%	1,023,203	(25,944)	(3%)	10,448,551	9,579,675	868,876	9%	10,033,009	415,542	4%
380	298	82	27%	293	87	30%	436	379	56	15%	380	56	15%
500,623	417,154	83,469	20%	409,164	91,459	22%	5,142,627	4,588,693	553,934	12%	4,596,683	545,944	12%
11,313,145	9,940,509	1,372,636	14%	10,258,060	1,055,085	10%	116,405,087	108,005,805	8,399,282	8%	105,923,623	10,481,465	10%
8,585	7,107	1,478	21%	7,334	1,251	17%	9,868	8,932	936	10%	8,760	1,108	13%
364,940	320,662	44,279	14%	330,905	34,035	10%	347,478	322,405	25,072	8%	316,190	31,288	10%

Key Financial Performance Indicators				Industry Benchmark	May-24	FYE 2024 Average	May-25	FYE 2025 Average	Feb-26	Mar-26	Apr-26	May-26	Variance to PM	Variance to FYE 2025 Average	Variance to PYM
Volume															
Admits		41	86		69	87	71	76	92	72	86		14	15	(1)
Deliveries	n/a		22		17	19	17	11	18	12	13		1	(4)	(6)
Adjusted Patient Days	n/a		1,321		977	1,399	1,125	903	1,001	1,266	1,318		52	193	(81)
Total Surgeries		153	140		146	123	140	127	151	146	142		(4)	2	19
ER Visits		659	896		826	899	852	838	893	767	857		90	5	(42)
RHC and Clinic Visits	n/a		4,999		4,607	4,911	4,772	4,448	4,936	4,823	4,492		(331)	(280)	(419)
Diagnostic Imaging Services	n/a		2,293		2,069	2,210	2,129	2,070	2,368	2,311	2,286		(25)	157	76
Rehab Services	n/a		970		662	865	838	867	917	944	843		(101)	5	(22)
AR & Income															
Gross AR (Cerner only)	n/a	\$ 53,102,112	\$ 52,823,707	\$ 49,751,818	\$ 50,813,697	\$ 45,756,586	\$ 48,086,679	\$ 46,907,846	\$ 48,573,893	\$ 1,666,048	\$ (2,239,804)	\$ (1,177,924)			
AR > 90 Days	\$ 6,599,901.18	\$ 22,672,126	\$ 23,112,391	\$ 20,779,018	\$ 20,669,422	\$ 13,901,792	\$ 15,208,624	\$ 15,741,875	\$ 16,878,857	\$ 1,136,982	\$ (3,790,564)	\$ (3,900,161)			
AR % > 90 Days	15%	43.41%	44.2%	41.8%	40.6%	30.4%	31.6%	33.6%	34.7%	1.2%	-5.8%	-7.0%			
Gross AR Days (per financial statements)	60	81	85	84	80	60	62	66	66	0	(14)	(18)			
Net AR Days (per financial statements)	30	43	58	83	71	35	40	52	53	2	(18)	(30)			
Net AR	n/a	\$ 13,540,975	\$ 16,938,200	\$ 24,454,016	\$ 19,370,868	\$ 26,841,775	\$ 27,435,133	\$ 30,351,013	\$ 27,024,016	\$ (3,326,997)	\$ 7,653,149	\$ 2,570,000			
Net AR % of Gross	n/a	25.5%	31.9%	49.2%	38.5%	58.7%	57.1%	64.7%	55.6%	-9.1%	17.1%	6.5%			
Gross Patient Revenue/Calendar Day	n/a	\$ 656,765	\$ 619,457	\$ 589,849	\$ 634,418	\$ 758,932	\$ 770,059	\$ 710,721	\$ 735,348	\$ 24,627	\$ 100,929	\$ 145,499			
Net Patient Revenue/Calendar Day	n/a	\$ 311,352	\$ 292,759	\$ 250,736	\$ 273,563	\$ 397,320	\$ 378,447	\$ 305,566	\$ 316,717	\$ 11,151	\$ 43,154	\$ 65,980			
Net Patient Revenue/APD	n/a	\$ 7,307	\$ 8,757	\$ 5,557	\$ 8,088	\$ 12,326	\$ 11,720	\$ 7,240	\$ 7,450	\$ 210	\$ (638)	\$ 1,893			
Wages															
Wages	n/a	\$ 3,311,797	\$ 3,285,431	\$ 3,599,495	\$ 3,661,965	\$ 3,442,161	\$ 3,839,305	\$ 3,851,445	\$ 3,684,604	\$ (166,841)	\$ 22,639	\$ 85,110			
Employed paid FTEs	n/a	357.91	353.69	375.45	370.77	374.44	388.32	387.36	367.32	(20.04)	(3.44)	(8.13)			
Employed Average Hourly Rate	\$55.50	\$ 52.24	\$ 53.49	\$ 54.27	\$ 56.89	\$ 57.61	\$ 55.97	\$ 58.16	\$ 56.78	\$ (1.38)	\$ (0.11)	\$ 2.51			
Benefits	n/a	\$ 1,571,990	\$ 1,640,216	\$ 1,155,616	\$ 1,401,858	\$ 1,489,133	\$ 2,111,276	\$ 1,271,979	\$ 1,840,959	\$ 568,980	\$ 439,101	\$ 685,343			
Benefits % of Wages	30%	47.5%	48.8%	32.1%	39.8%	43.3%	55.0%	33.0%	50.0%	16.9%	10.2%	17.9%			
Contract Labor	n/a	\$ 968,946	\$ 518,351	\$ 392,345	\$ 447,445	\$ 256,756	\$ 280,557	\$ 426,165	\$ 484,968	\$ 58,803	\$ 37,523	\$ 92,623			
Contract Labor Paid FTEs	n/a	29.72	23.49	19.69	23.89	19.44	19.83	20.79	19.76	(1.03)	(4.13)	0.06			
Total Paid FTEs	n/a	387.63	377.18	395.14	394.65	393.87	408.16	408.15	387.08	(21.07)	(7.58)	(8.06)			
Contract Labor Average Hourly Rate	\$ 81.04	\$ 184.04	\$ 123.22	\$ 112.79	\$ 120.98	\$ 82.79	\$ 80.07	\$ 119.91	\$ 138.96	\$ 19.05	\$ 17.98	\$ 26.17			
Total Salaries, Wages, & Benefits	n/a	\$ 5,852,733	\$ 5,443,998	\$ 5,147,456	\$ 5,511,268	\$ 5,188,050	\$ 6,231,139	\$ 5,549,590	\$ 6,010,531	\$ 460,942	\$ 499,263	\$ 863,076			
SWB% of NR	50%	60.6%	62.1%	66.2%	72.0%	46.6%	53.1%	60.5%	61.2%	0.7%	-10.8%	-5.0%			
SWB/APD	2,204	\$ 4,431	\$ 5,104	\$ 3,680	\$ 5,284	\$ 5,748	\$ 6,225	\$ 4,383	\$ 4,561	\$ 178	\$ (723)	\$ 881			
SWB % of total expenses	50%	58.5%	55.4%	50.2%	55.6%	51.7%	52.9%	50.2%	53.1%	2.9%	-2.5%	2.9%			

			Industry											
			Benchmark	May-24	FYE 2024 Average	May-25	FYE 2025 Average	Feb-26	Mar-26	Apr-26	May-26	Variance to PM	Variance to FYE 2025 Average	Variance to PYM
Physician Spend	Physician Expenses		n/a	\$ 1,878,965	\$ 1,613,172	\$ 1,780,354	\$ 1,507,510	\$ 1,737,862	\$ 1,937,506	\$ 2,127,062	\$ 1,802,579	\$ (324,483)	\$ 295,069	\$ 22,225
	Physician expenses/APD		n/a	\$ 1,343	\$ 1,565	\$ 1,273	\$ 1,476	\$ 1,925	\$ 1,935	\$ 1,680	\$ 1,368	\$ (312)	\$ (108)	\$ 95
Supplies														
	Supply Expenses		n/a	\$ 579,458	\$ 832,644	\$ 746,075	\$ 776,504	\$ 900,674	\$ 930,897	\$ 1,201,928	\$ 1,261,625	\$ 59,697	\$ 485,122	\$ 515,550
	Supply expenses/APD			\$ 414	\$ 822	\$ 533	\$ 744	\$ 998	\$ 930	\$ 949	\$ 957	\$ 8	\$ 213	\$ 424
Other Expenses														
	Other Expenses		n/a	\$ 2,652,181	\$ 1,939,040	\$ 2,330,552	\$ 1,824,207	\$ 2,212,109	\$ 2,672,831	\$ 2,180,443	\$ 2,238,409	\$ 57,966	\$ 414,202	\$ (92,143)
	Other Expenses/APD		n/a	\$ 1,896	\$ 1,861	\$ 1,666	\$ 1,787	\$ 2,451	\$ 2,670	\$ 1,722	\$ 1,699	\$ (24)	\$ (88)	\$ 32
Margin														
	Net Income		n/a	\$ (2,134,682)	\$ 253,100	\$ (36,142)	\$ 383,722	\$ 6,301,475	\$ 486,988	\$ (1,013,007)	\$ 1,318,651	\$ 2,331,659	\$ 934,930	\$ 1,354,793
	Net Profit Margin		n/a	-27.5%	3.7%	-0.4%	3.0%	56.6%	4.2%	-11.1%	13.4%	24.5%	10.5%	13.8%
	Operating Income		n/a	\$ (2,485,229)	\$ (1,557,761)	\$ (352,524)	\$ (686,444)	\$ 1,086,276	\$ (40,522)	\$ (1,892,040)	\$ (1,494,921)	\$ 397,120	\$ (808,476)	\$ (1,142,396)
	Operating Margin	2.9%		-32.0%	-26.1%	-3.7%	-10.9%	9.8%	-0.3%	-20.6%	-15.2%	5.4%	-4.3%	-11.6%
	EBITDA		n/a	\$ (1,725,518)	\$ 676,999	\$ 411,699	\$ 841,891	\$ 6,944,209	\$ 980,998	\$ (514,664)	\$ 1,819,274	\$ 2,333,938	\$ 977,384	\$ 1,407,576
	EBITDA Margin	12.7%		-22.2%	9.4%	4.3%	8.7%	62.4%	8.4%	-5.6%	18.5%	24.1%	9.8%	14.3%
	Debt Service Coverage Ratio	3.70		307.1%	3.9	3.6	3.3	4.7	3.5	3.2	3.5	0.3	0.1	(0.1)
Cash														
	Avg Daily Disbursements (excl. IGT)		n/a	\$ 359,335	\$ 350,828	\$ 342,362	\$ 355,328	\$ 388,193	\$ 363,206	\$ 624,096	\$ 694,374	\$ 70,278	\$ 339,046	\$ 352,012
	Average Daily Cash Collections (excl. IGT)		n/a	\$ 359,285	\$ 340,919	\$ 294,096	\$ 299,110	\$ 313,515	\$ 328,025	\$ 384,546	\$ 457,527	\$ 72,981	\$ 158,416	\$ 163,430
	Average Daily Net Cash			\$ (50)	\$ (9,908)	\$ (48,265)	\$ (56,218)	\$ (74,679)	\$ (35,181)	\$ (239,550)	\$ (236,848)	\$ 2,703	\$ (180,630)	\$ (188,582)
	Upfront Cash Collections			\$ 81,100	\$ 54,286	\$ 34,412	\$ 36,146	\$ 67,508	\$ 88,629	\$ 74,703	\$ 63,036	\$ (11,667)	\$ 26,890	\$ 28,623
	Upfront Cash % of Gross Charges	1%		0.4%	0.3%	0.2%	0.2%	0.3%	0.4%	0.4%	0.3%	-0.1%	0.1%	0.1%
	Unrestricted Funds		n/a	\$ 27,908,135	\$ 23,774,285	\$ 27,788,508	\$ 23,536,438	\$ 23,811,084	\$ 32,334,262	\$ 34,024,342	\$ 37,776,129	\$ 3,751,786	\$ 14,239,691	\$ 9,987,621
	Change of cash per balance sheet		n/a	\$ 219,197	\$ 321,485	\$ 13,346,102	\$ (321,485)	\$ 686,454	\$ 8,523,178	\$ 1,690,081	\$ 3,751,786	\$ 2,061,706	\$ 4,073,272	\$ (9,594,316)
	Days Cash on Hand (assume no more cash is collected)	196		92	73	90	72	74	99	103	114	11	42	24
	Estimated Days Until Depleted (operating cash only)			676	2,399	482	406	411	583	461	426	(35)	20	(56)
	Years Until Cash Depletion (operating cash only)			1.85	6.57	1.32	1.11	1.12	1.60	1.26	1.17	(0.09)	0.06	(0.15)

NIHD Financial Update

Chief Financial Officer

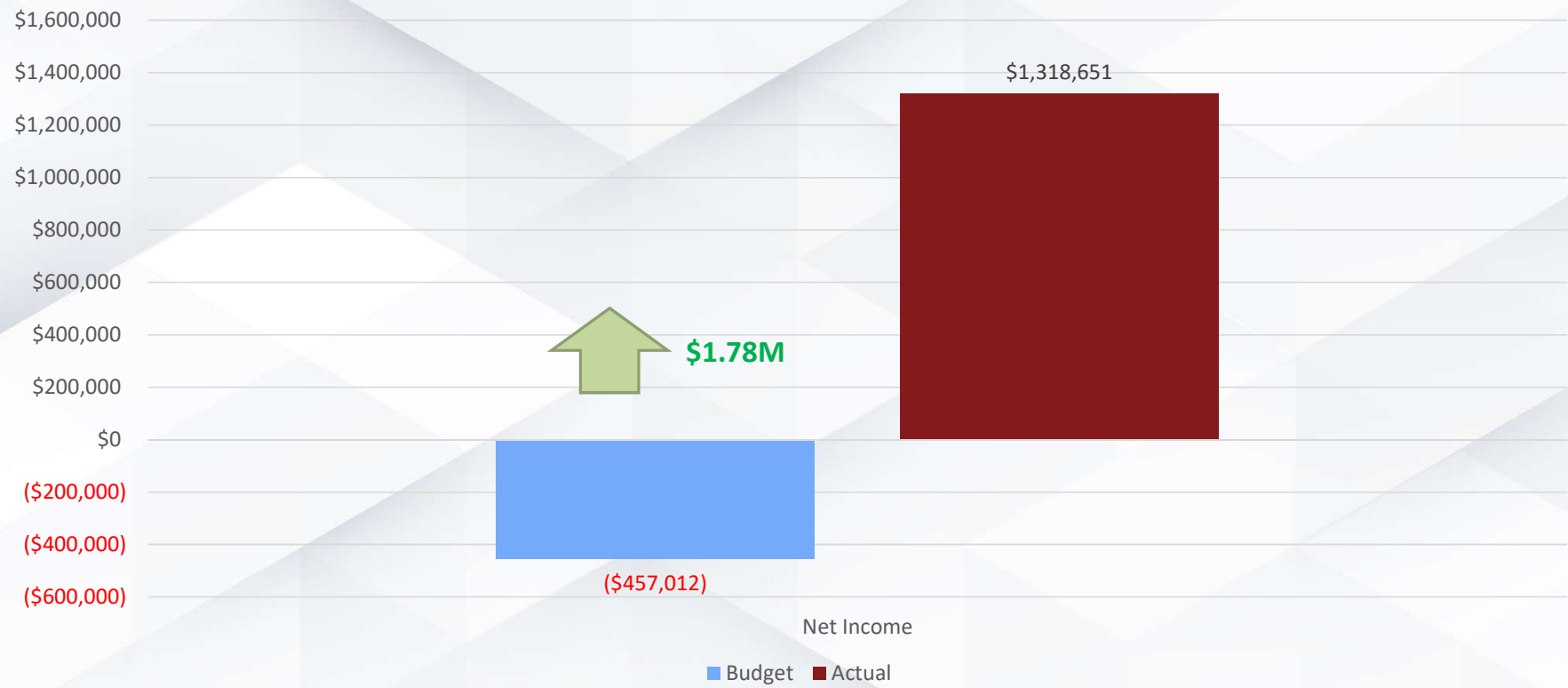
May 2026 Results



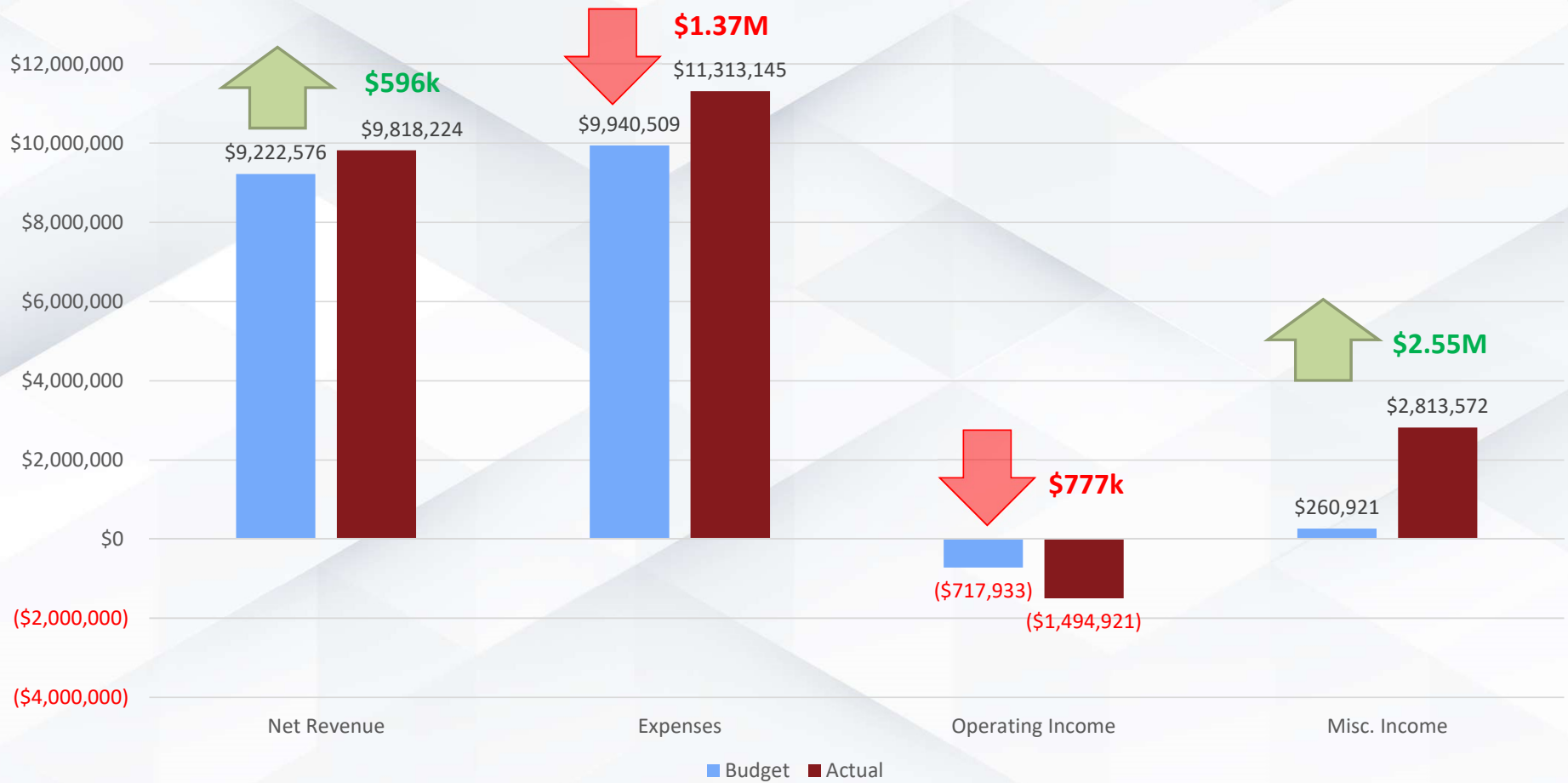
NORTHERN INYO HEALTHCARE DISTRICT

INCOME PERFORMANCE

Net Income



Income to Budget



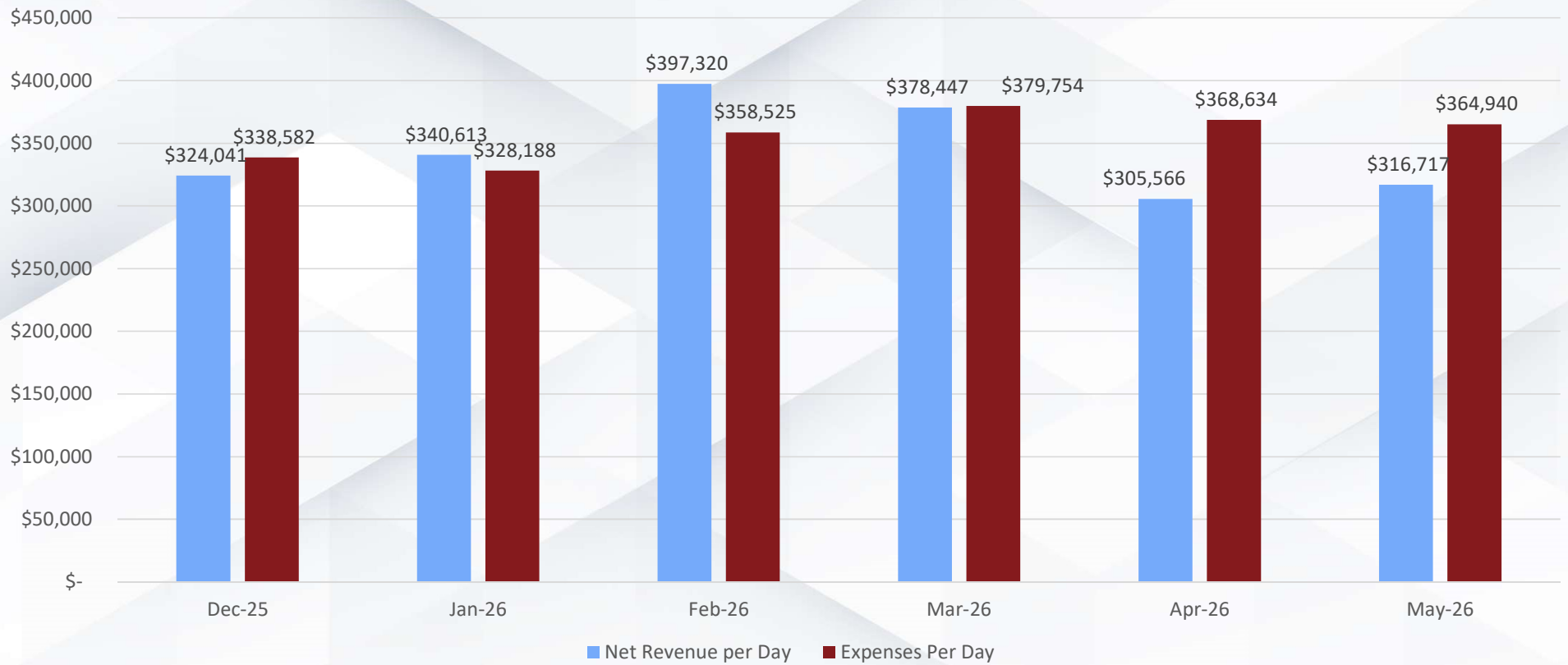
Income trend



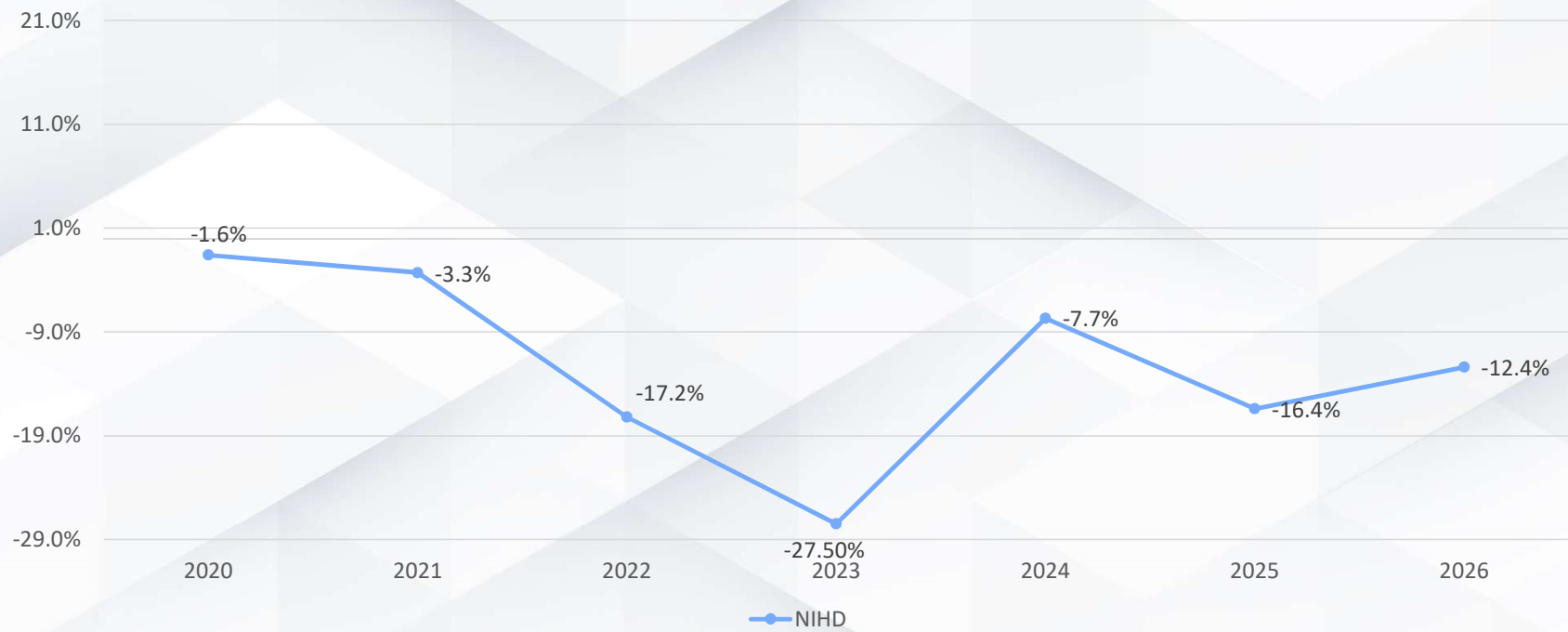
Net Profit Margin



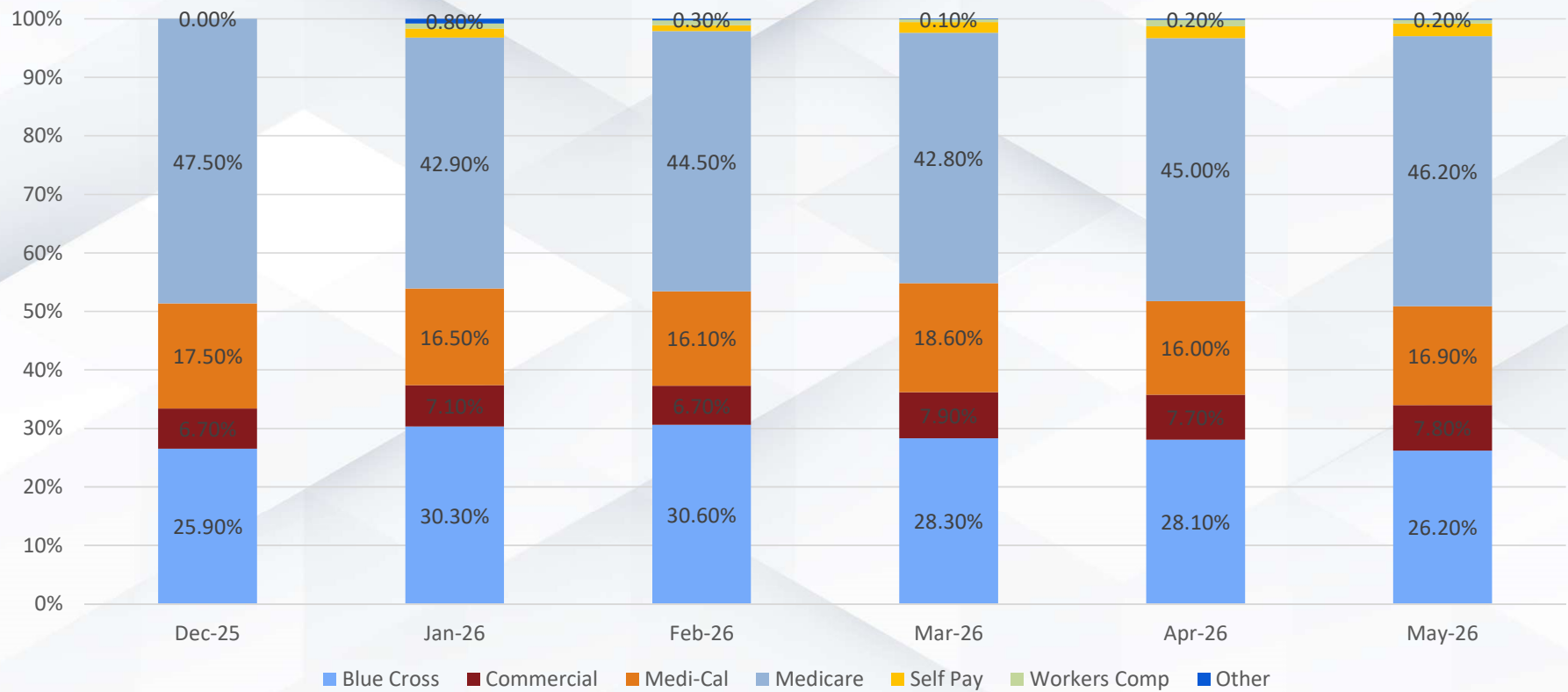
Trend per calendar day



Operating Margin



Payor Mix trend



Wage Costs

	YTD 2025	YTD 2026	YTD Budget
Total Paid FTEs	393.9	398.2	393.9
Salaries, Wages, Benefits (SWB) Expense (incl. contract labor)	\$57,506,571	\$60,996,089	\$57,767,985
SWB % of total expenses (including contract labor)	54%	52%	53%
Employed Average Hourly Rate	\$51.49	\$56.16	\$52.11
Benefits % of Wages	45%	40%	45%

Volume & Income Action plan

- The Mammoth Orthopedic Institute began orthopedic surgeries in July. Their surgical volume has steadily increased. Orthopedic surgeries exceeded their budget. Additionally general and urology surgeries are also exceeding budget.
- We are working on reviewing operational efficiency including OR utilization and space utilization reviews to maximize patient flow and care.
- We are being more deliberate in our service line strategy.
- We are working on a staff benchmarking analysis to determine if we are appropriately staffing by skill mix in all departments.
- Leaders are doing a great job of managing their expenses.

Cash Performance

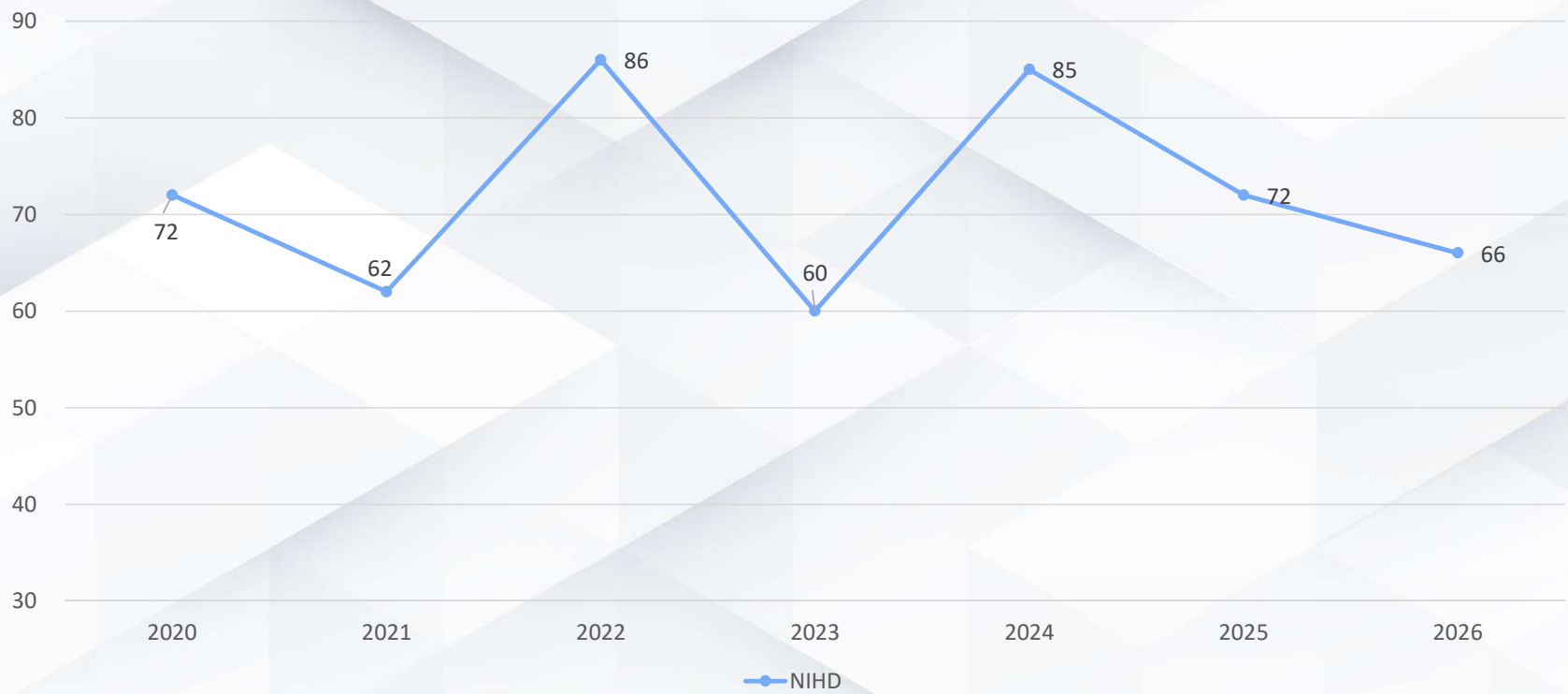


NORTHERN INYO HEALTHCARE DISTRICT

Income to Cash

	FYE 2026
Net Income (loss)	\$5,750,268
Principal Payments on Long-Term Debt (balance sheet only)	\$(1,942,891)
Other Debt (long-term leases & subscriptions – balance sheet only)	\$(1,020,604)
Capital purchases (balance sheet only)	\$(2,173,696)
Employee Retention Credit (accrued in income last FY)	\$4,075,952
Timing of Accruals vs. Cash	\$4,587,545
Impact to Cash	\$3,526,306
Adjusted Net Income (cash basis)	\$9,276,574

Gross AR Days



Debt Service Coverage Ratio



Days Cash on Hand



Unrestricted Funds



Cash action plan

- The cash flow action team is working to improve processes in all aspects of billing and collections.
- We have hired a new AI-based billing company, Jorie, and have hit record cash collections the past few months. The automation is now live in several areas.
- We have moved \$24M in cash to Five Star Bank to earn better returns on our cash.
- We have another \$11M in the LAIF Earning over 4% interest.
- AR days are at a record low for the organization.

Northern Inyo Healthcare District
Income Statement
Fiscal Year 2026

	3/31/2026	Mar Budget	3/31/2025	4/30/2026	Apr Budget	4/30/2025	5/31/2026	May Budget	5/31/2025	2026 YTD	2025 YTD	Budget Variance	PYM Change
Gross Patient Service Revenue													
Inpatient Patient Revenue	5,985,858	3,643,136	6,901,902	3,901,381	3,596,335	3,003,097	4,196,525	3,716,213	3,371,624	44,874,287	3,914,942	480,312	824,901
Outpatient Revenue	15,833,078	14,386,230	13,051,580	15,480,289	14,221,947	13,297,993	16,694,284	14,695,389	13,103,211	163,531,666	152,515,200	1,998,894	3,591,072
Clinic Revenue	2,052,895	1,735,007	1,718,306	1,939,954	1,727,250	1,891,743	1,904,971	1,784,825	1,810,472	21,661,067	19,422,853	120,145	94,499
Gross Patient Service Revenue	23,871,832	19,764,372	21,671,787	21,321,624	19,545,532	18,192,833	22,795,779	20,196,427	18,285,307	230,067,020	212,711,874	2,599,352	4,510,472
Deductions from Revenue													
Contractual Adjustments	(11,883,671)	(9,943,164)	(10,138,614)	(11,804,084)	(9,622,417)	(8,841,205)	(12,797,977)	(9,943,164)	(7,499,521)	(119,591,245)	(101,150,225)	(2,854,813)	(5,298,457)
Bad Debt	(1,107,080)	(119,730)	(370,446)	26,871	(115,868)	(3,774,465)	63,117	(119,730)	(2,837,626)	(3,686,110)	(6,971,246)	182,848	2,900,743
A/R Writeoffs	(458,960)	(731,396)	(176,044)	(377,429)	(707,802)	(179,014)	(242,695)	(731,396)	(177,633)	(4,513,674)	(8,286,515)	488,701	(65,062)
Other Deductions from Revenue	1,309,730	(179,562)	-	-	(173,770)	-	-	(179,562)	-	1,309,730	(152,618)	179,562	-
Deductions from Revenue	(12,139,981)	(10,973,852)	(10,685,103)	(12,154,642)	(10,619,856)	(12,794,684)	(12,977,555)	(10,973,852)	(10,514,779)	(126,481,300)	(116,560,604)	(2,003,703)	(2,462,775)
Other Patient Revenue													
Incentive Income	-	-	-	-	-	-	-	-	2,304	-	4,304	-	(2,304)
Other Oper Rev - Rehab Thera Serv	-	-	-	-	-	-	-	-	-	-	2,435	-	-
Medical Office Net Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Patient Revenue	-	-	-	-	-	-	-	-	2,304	-	6,738	-	(2,304)
Net Patient Service Revenue	11,731,850	8,790,521	10,986,684	9,166,983	8,925,676	5,398,149	9,818,224	9,222,576	7,772,831	103,585,720	96,158,009	595,649	2,045,393
CNR%	49.1%	44.5%	50.7%	43.0%	45.7%	29.7%	43.1%	45.7%	42.5%	45.0%	45.2%	-2.6%	0.6%
Cost of Services - Direct													
Salaries and Wages	3,271,550	3,435,715	2,997,295	3,241,797	3,326,869	3,078,978	3,158,248	3,435,715	3,089,016	34,605,165	30,887,479	(277,466)	69,233
Benefits	1,776,950	1,512,150	1,425,501	1,118,914	1,489,410	1,277,083	1,587,950	1,536,859	935,894	14,004,205	13,851,078	51,091	652,056
Professional Fees	2,104,413	2,396,473	2,013,306	2,354,887	2,355,988	1,903,652	1,997,032	2,383,227	2,159,742	22,095,122	20,335,121	(386,195)	(162,709)
Contract Labor	243,243	361,796	187,691	281,325	353,063	355,281	314,495	361,796	292,586	2,938,171	3,984,100	(47,301)	21,909
Pharmacy	529,919	451,577	755,356	571,051	437,010	327,061	485,963	451,577	331,813	4,857,323	4,216,124	34,386	154,150
Medical Supplies	400,978	442,517	303,803	630,877	427,637	289,061	775,662	442,142	247,645	5,938,116	4,780,159	333,520	528,017
Hospice Operations	-	-	-	-	-	-	-	-	-	-	-	-	-
EHR System Expense	31,525	32,115	20,415	34,915	32,115	44,592	31,361	32,115	49,037	395,888	387,726	(754)	(17,676)
Other Direct Expenses	756,649	876,969	585,010	750,237	865,217	602,461	728,903	879,924	737,203	7,723,459	7,278,176	(151,022)	(8,301)
Total Cost of Services - Direct	9,115,227	9,509,311	8,288,377	8,984,004	9,287,308	7,878,169	9,079,615	9,523,355	7,842,936	92,557,450	85,719,963	(443,741)	1,236,679
General and Administrative Overhead													
Salaries and Wages	567,755	-	514,529	609,648	-	724,391	526,356	-	510,479	6,092,165	5,560,503	526,356	15,877
Benefits	334,327	-	241,966	153,065	-	138,697	253,009	-	219,722	2,354,853	2,375,566	253,009	33,287
Professional Fees	916,493	-	494,527	411,662	-	431,885	514,713	-	890,001	6,531,372	4,068,230	514,713	(375,288)
Contract Labor	37,315	-	95,330	144,840	-	97,467	170,473	-	99,759	1,001,529	847,845	170,473	70,714
Depreciation and Amortization	494,010	417,154	409,164	498,344	417,154	409,164	500,623	417,154	409,164	5,142,627	4,596,683	83,469	91,459
Other Administrative Expenses	307,245	-	251,163	257,460	-	277,268	268,356	-	285,999	2,725,092	2,754,833	268,356	(17,643)
Total General and Administrative Overhead	2,657,146	417,154	2,006,679	2,075,019	417,154	2,078,872	2,233,530	417,154	2,415,124	23,847,638	20,203,659	1,816,376	(181,594)
Total Expenses	11,772,372	9,926,465	10,295,056	11,059,023	9,704,462	9,957,041	11,313,145	9,940,509	10,258,060	116,405,087	105,923,623	1,372,636	1,055,085
Financing Expense	170,574	196,180	201,224	162,781	196,180	194,928	171,352	196,180	198,265	1,925,984	2,198,284	(24,828)	(26,913)
Financing Income	381,929	78,984	78,984	414,751	190,806	903,825	1,067,033	197,166	250,741	4,556,611	2,897,257	869,867	816,292
Investment Income	82,241	47,322	49,720	339,523	47,322	58,156	113,844	47,322	54,996	1,335,267	531,982	66,522	58,848
Miscellaneous Income	233,914	397,786	145,639	287,539	209,364	69,492	1,804,046	212,613	243,075	14,603,741	11,365,155	1,591,434	1,560,972
Net Income (Change in Financial Position)	486,988	(808,032)	764,746	(1,013,007)	(527,473)	(3,722,346)	1,318,651	(457,012)	(2,134,682)	5,750,268	2,830,496	1,775,663	3,453,333
Operating Income	(40,522)	(1,135,945)	691,628	(1,892,040)	(778,786)	(4,558,891)	(1,494,921)	(717,933)	(2,485,229)	(12,819,367)	(9,765,614)	(776,987)	990,309
EBIDA	980,998	(390,879)	1,173,910	(514,664)	(110,319)	(3,313,182)	1,819,274	(39,858)	(1,725,518)	10,892,894	7,427,178	1,859,133	3,544,792
Net Profit Margin	4.2%	-9.2%	7.0%	-11.1%	-5.9%	-69.0%	13.4%	-5.0%	-27.5%	5.6%	2.9%	18.4%	29.2%
Operating Margin	-0.3%	-12.9%	6.3%	-20.6%	-8.7%	-84.5%	-15.2%	-7.8%	-32.0%	-12.4%	-10.2%	-7.4%	31.6%
EBIDA Margin	8.4%	-4.4%	10.7%	-5.6%	-1.2%	-61.4%	18.5%	-0.4%	-22.2%	10.5%	7.7%	19.0%	27.8%

Northern Inyo Healthcare District
Balance Sheet
Fiscal Year 2026

	PY Balances	3/31/2026	3/31/2025	4/30/2026	4/30/2025	5/31/2026	5/31/2025	PM Change	PY Change
Assets									
Current Assets									
Cash and Liquid Capital	20,757,956	21,007,812	18,774,677	22,886,679	19,449,093	26,638,540	19,669,998	3,751,861	6,968,542
Short Term Investments	7,741,599	11,076,390	7,253,236	11,137,664	7,742,770	11,137,589	7,741,372	(75)	3,396,217
PMA Partnership	-	-	-	-	-	-	-	-	-
Accounts Receivable, Net of Allowance	16,645,748	27,435,133	18,641,177	30,351,013	12,663,338	27,024,016	24,454,016	(3,326,997)	2,570,000
Other Receivables	9,238,007	4,811,775	9,013,770	(1,058,088)	9,700,579	(1,480,505)	(1,534,786)	(422,417)	54,281
Inventory	5,334,241	5,359,679	7,049,031	5,345,142	7,043,517	5,345,559	7,034,856	417	(1,689,297)
Prepaid Expenses	1,106,127	1,870,160	1,195,648	1,741,924	1,277,412	1,660,627	900,565	(81,298)	760,062
Total Current Assets	60,823,678	71,560,949	61,927,539	70,404,334	57,876,709	70,325,825	58,266,021	(78,509)	12,059,805
Assets Limited as to Use									
Internally Designated for Capital Acquisition:	-	-	-	-	-	-	-	-	-
Short Term - Restricted	1,469,292	(711,051)	1,468,917	129,810	1,469,040	129,939	1,469,168	128	(1,339,230)
Limited Use Assets	-	-	-	-	-	-	-	-	-
LAIF - DC Pension Board Restricted	-	-	-	-	-	-	-	-	-
LAIF - DB Pension Board Restricted	9,393,030	9,393,030	13,882,457	9,393,030	13,882,457	9,393,030	13,882,457	-	(4,489,427)
PEPRA - Deferred Outflows	-	-	-	-	-	-	-	-	-
PEPRA Pension	-	-	-	-	-	-	-	-	-
Deferred Outflow - Excess Acquisition	573,097	573,097	573,097	573,097	573,097	573,097	573,097	-	-
Total Limited Use Assets	9,966,127	9,966,127	14,455,554	9,966,127	14,455,554	9,966,127	14,455,554	-	(4,489,427)
Revenue Bonds Held by a Trustee	297,382	246,484	324,871	241,007	319,127	235,529	313,383	(5,477)	(77,854)
Total Assets Limited as to Use	11,732,801	9,501,560	16,249,342	10,336,944	16,243,722	10,331,595	16,238,105	(5,349)	(5,906,510)
Long Term Assets									
Long Term Investment	497,086	250,060	(597,117)	-	497,075	-	496,765	-	(496,765)
Fixed Assets, Net of Depreciation	81,644,252	78,707,951	83,170,782	78,315,524	82,773,362	77,978,700	82,508,539	(336,824)	(4,529,839)
Total Long Term Assets	82,141,338	78,958,011	82,573,665	78,315,524	83,270,437	77,978,700	83,005,303	(336,824)	(5,026,603)
Total Assets	154,697,817	160,020,520	160,750,547	159,056,802	157,390,868	158,636,120	157,509,429	(420,682)	1,126,691
Liabilities									
Current Liabilities									
Current Maturities of Long-Term Debt	3,599,764	3,561,107	4,312,667	3,556,887	4,300,283	3,661,147	4,391,066	104,260	(729,919)
Accounts Payable	4,413,297	5,456,295	3,592,092	5,174,270	3,663,678	4,997,597	4,392,528	(176,674)	605,069
Accrued Payroll and Related	3,525,333	5,021,515	3,268,949	5,366,893	3,524,904	4,116,268	3,941,303	(1,250,625)	174,965
Accrued Interest and Sales Tax	83,538	265,033	144,235	102,872	220,309	14,720	141,308	(88,152)	(126,588)
Notes Payable	339,892	339,892	446,860	339,892	446,860	229,820	339,892	(110,072)	(110,072)
Unearned Revenue	-	-	(4,542)	-	(4,542)	-	(4,542)	-	4,542
Due to 3rd Party Payors	3,324,903	4,331,882	1,637,684	4,331,882	1,637,684	4,125,564	(333,316)	(206,318)	4,458,880
Due to Specific Purpose Funds	-	-	-	-	-	-	-	-	-
Other Deferred Credits - Pension & Leases	8,758,790	8,740,163	12,581,197	8,740,163	12,579,127	8,740,163	12,577,057	(0)	(3,836,894)
Total Current Liabilities	24,045,518	27,715,888	25,979,142	27,612,860	26,368,305	25,885,279	25,445,296	(1,727,580)	439,983
Long Term Liabilities									
Long Term Debt	33,367,666	30,376,414	33,749,977	30,283,079	33,648,895	30,178,498	33,547,552	(104,581)	(3,369,054)
Bond Premium	127,973	99,740	137,384	96,603	134,247	93,465	131,110	(3,137)	(37,645)
Accreted Interest	17,272,679	17,130,702	17,009,899	17,215,090	17,094,610	17,299,478	17,183,644	84,388	115,833
Other Non-Current Liability - Pension	31,874,258	31,874,258	32,946,355	31,874,258	32,946,355	31,874,258	32,946,355	-	(1,072,097)
Total Long Term Liabilities	82,642,576	79,481,114	83,843,615	79,469,030	83,824,107	79,445,699	83,808,662	(23,330)	(4,362,963)
Suspense Liabilities	-	-	-	-	-	-	-	-	-
Uncategorized Liabilities (grants)	61,310	114,957	139,321	114,957	139,321	114,957	139,321	-	(24,364)
Total Liabilities	106,749,404	107,311,959	109,962,078	107,196,846	110,331,732	105,445,935	109,393,279	(1,750,911)	(3,947,344)
Fund Balance									
Fund Balance	40,722,935	45,793,513	40,632,146	45,957,791	40,624,917	45,969,241	43,816,486	11,449	2,152,755
Temporarily Restricted	1,469,292	1,470,424	1,468,799	1,470,548	1,469,040	1,470,676	1,469,168	128	1,508
Net Income	5,756,186	5,444,624	8,687,524	4,431,616	4,965,178	5,750,268	2,830,496	1,318,651	2,919,772
Total Fund Balance	47,948,412	52,708,561	50,788,469	51,859,956	47,059,136	53,190,185	48,116,150	1,330,229	5,074,034
Liabilities + Fund Balance	154,697,817	160,020,520	160,750,547	159,056,802	157,390,868	158,636,120	157,509,429	(420,682)	1,126,691
(Decline)/Gain		643,551	4,447,593	(963,718)	(3,359,679)	(420,682)	118,561	543,036	(539,243)

Northern Inyo Healthcare District
Long-Term Debt Service Coverage Ratio
FYE 2026

Calculation method agrees to SECOND and THIRD
SUPPLEMENTAL INDENTURE OF TRUST 2021 Bonds Indenture

Long-Term Debt Service Coverage Ratio Calculation

Numerator:

Excess of revenues over expense
+ Depreciation Expense
+ Interest Expense
Less GO Property Tax revenue
Less GO Interest Expense

HOSPITAL FUND ONLY

\$	5,750,268
	5,142,627
	1,925,984
	3,697,439
	421,992

"Income available for debt service"

\$	8,699,447
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Denominator:

Maximum "Annual Debt Service"

2021A Revenue Bonds
2021B Revenue Bonds
2009 GO Bonds (Fully Accreted Value)
2016 GO Bonds
Financed purchases and other loans

\$	112,700
	892,400
	1,506,725
\$	2,511,825

Total Maximum Annual Debt Service

Ratio: (numerator / denominator)

3.46

Required Debt Service Coverage Ratio:

1.10

In Compliance? (Y/N)

Yes

Unrestricted Funds and Days Cash on Hand

HOSPITAL FUND ONLY

Cash and Investments-current
Cash and Investments-non current
Sub-total
Less - Restricted:
PRF and grants (Unearned Revenue)
Held with bond fiscal agent
Building and Nursing Fund

\$	37,776,129
	-
	37,776,129
	-
	-
	-
\$	37,776,129

Total Unrestricted Funds

Total Operating Expenses
Less Depreciation
Net Expenses
Average Daily Operating Expense

\$	116,405,087
	5,142,627
	111,262,461
\$	332,127

Days Cash on Hand

114

Northern Inyo Healthcare District
Statement of Cash Flows
Fiscal Year 2026

CASH FLOWS FROM OPERATING ACTIVITIES

Receipts from and on Behalf of Patients	103,625,669
Payments to Suppliers and Contractors	(40,389,560)
Payments to and on Behalf of Employees	(60,996,089)
Other Receipts and Payments, Net	4,075,952
Net Cash Provided (Used) by Operating Activities	<u>6,315,971</u>

CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES

Noncapital Contributions and Grants	7,802,697
Property Taxes Received	859,172
Net Cash Provided (Used) by Noncapital Financing Activities	<u>8,661,869</u>

**CASH FLOWS FROM CAPITAL AND CAPITAL RELATED
FINANCING ACTIVITIES**

Principal Payments on Long-Term Debt	(1,942,891)
Proceeds from the Issuance of Refunding Revenue Bonds	-
Payment to Defease Revenue Bonds	-
Interest Paid	(1,925,984)
Purchase and Construction of Capital Assets	(2,173,696)
Payments on Lease Liability	(97,868)
Payments on Subscription Liability	(922,736)
Property Taxes Received	(32,822)
Net Cash Provided (Used) by Capital and Capital Related Financing Activities	<u>(7,095,996)</u>

CASH FLOWS FROM INVESTING ACTIVITIES

Investment Income	1,335,267
Rental Income	59,464
Net Cash Provided (Used) by Investing Activities	<u>1,394,730</u>

NET CHANGE IN CASH AND CASH EQUIVALENTS

9,276,574

Cash and Cash Equivalents - Beginning of Year

28,499,555

CASH AND CASH EQUIVALENTS - END OF YEAR

37,776,129

Advocacy Tracker

Priority	Legislation	Description	Status
1	AB 1923 - Soria	Distressed Hospital Loan Program - \$250 million Expands and funds California's Distressed Hospital Loan Program to provide financial assistance to hospitals at risk of closure. The bill broadens eligibility and allows for loan forgiveness based on financial need, with the goal of stabilizing hospital operations. It is intended to preserve access to care, particularly in rural and underserved communities.	Introduced (2/12/26) Passed Assembly Health Committee (15-0 on 4/23/26) Passed Assembly Appropriations Committee (5/14/26) (P Passed the Assembly (78-0 on 5/27/26) Referred to the Senate Health Committee (6/10/26) Passed Senate Health Committee
1	AB 2353 - Pacheco	Requires review of any new mandate for hospitals Requires an independent evaluation of legislation that imposes new requirements on hospitals to assess its cost and impact on healthcare affordability. The bill aims to provide lawmakers with better information on how proposed policies affect hospital operations and overall healthcare costs. It is intended to improve decision-making and prevent unintended financial strain on hospitals and the healthcare system. Update: The bill now establishes the Health Mandates Review Program and the Center for Health Provider Policy Impact to provide independent analyses of proposed hospital mandates and their impacts on hospital operations, healthcare affordability, workforce, and access to care before new requirements are enacted.	Passed Assembly Health Committee (11-0 on 4/21/26) Passed Assembly Appropriations Committee (12-0 on 5/1 Passed the Assembly (56-1 on 5/27/26) Referred to the Senate Health Committee (6/10/26) Senate Health Committee - Hearing cancelled

Advocacy Tracker

Priority	Legislation	Description	Status
1	AB 2208 - Stefani	Maintains three month retroactive eligibility for Medi-Cal. Puts in place co pays for Medi-Cal as required by HR-1 maintains the current three-month retroactive eligibility period for Medi-Cal, allowing patients to receive coverage for services provided prior to enrollment. The bill also implements cost-sharing requirements, including co-pays, in alignment with federal policy changes under H.R. 1. It is intended to preserve access to coverage while aligning Medi-Cal policies with federal requirements.	Introduced (2/19/26) Passed Assembly Health Committee Passed Assembly Appropriations Committee Passed the Assembly Referred to the Senate Health Committee (6/10/26) Passed Senate Health Committee (7/1/26) Referred to Senate Appropriations Committee
1	AB 1607 - M. Gonzalez	Extension of sunset for Maddy Emergency Medical Services Fund Removes the sunset on counties' authority to levy penalties that fund the Maddy Emergency Medical Services (EMS) Fund, maintaining the funding mechanism for emergency medical and trauma services. By preserving this funding structure, the bill supports continued operation of EMS systems. These services are critical to maintaining access to emergency care, particularly in rural and underserved communities. Update: Extends funding for the Maddy EMS Fund and Richie's Fund through January 1, 2037.	Passed Assembly Health Committee (16-0 on 3/24/26) Passed Assembly Public Safety Committee (9-0 on 4/14/26) Passed the Assembly (72-1 on 4/20/26) Passed Senate Health Committee (11-0 on 6/17/26) Re-referred to the Senate Public Safety Committee (6/18/26) Passed Senate Public Safety Committee (6-0 on 7/1/26)

Advocacy Tracker

Priority	Legislation	Description	Status
1	HR 8209 - Tonko	Bipartisan legislation introduced to extend School-Based Health Centers grant program through 2031 The SBHC grant program provides competitive funding to support the establishment and operation of school-based health centers. Grants can be used to acquire or lease equipment, support workforce training, pay staff salaries and cover operational and management costs. The program prioritizes communities facing significant barriers to care, including areas with high rates of uninsured children. Update: Awaits consideration by the full House of Representatives. It would authorize \$55 million annually for FY 2027–2031 to support School-Based Health Centers.	Introduced (4/6/26) Passed House Energy & Commerce Health Subcommittee Passed House Energy & Commerce Committee (46-0 on 4/29/26) Awaiting consideration by the full House of Representatives
2	AB 1811 - Rogers	Health Professions Shortage Areas preservation These designations support recruitment and retention of healthcare providers by maintaining eligibility for existing federal and state incentive programs, such as loan repayment and grants. The bill is intended to preserve provider availability in underserved and rural communities. Update: The bill was amended to preserve Health Professional Shortage Area (HPSA) designations that existed on January 1, 2025, through January 1, 2035, ensuring affected communities remain eligible for state incentive programs despite changes to federal HPSA designations.	Passed Assembly Health Committee (16-0 on 3/24/26) Passed Assembly Appropriations Committee (15-0 on 5/6/26) Passed the Assembly (79-0 on 5/14/26) Referred to Senate Health Committee (Was not heard in committee)

Advocacy Tracker

Priority	Legislation	Description	Status
2	AB 2282 - Alanis	Free Standing Emergency Department for Del Puerto HCD Authorizes the establishment of a freestanding emergency department in the Del Puerto area to expand access to emergency medical services. The bill is intended to address gaps in emergency care availability in a rural and underserved region. It supports improved access to timely care where hospital-based emergency services are not readily available.	Passed Assembly Health Committee (16-0 on 4/22/26) Passed Assembly Appropriations Committee (15-0 on 5/1/26) Passed the Assembly (76-0 on 5/29/26) Referred to the Senate Health Committee (6/11/26) Passed Senate Health Committee (7/1/26)
2	AB 2311 - Schiavo	Healthcare Districts hiring physicians Expands the authority of healthcare districts to employ physicians and directly provide medical services. The bill is intended to improve access to care by allowing districts greater flexibility in staffing and service delivery. It supports rural and underserved communities where recruiting and retaining providers is a challenge.	Passed Assembly Health Committee (17-0 on 4/22/26) Passed Assembly Appropriations Committee (15-0 on 5/1/26) Passed the Assembly (79-0 on 5/29/26) Referred to the Senate Health Committee (6/11/26) Passed Senate Health Committee (7/1/26)
2	SB 1187 - Durazo	Brown Act - Relates to what makes majority for a legislative body Clarifies that a majority under the Brown Act is based on the total number of authorized board seats, including vacancies. The bill is intended to eliminate ambiguity and ensure consistent application of open meeting requirements for local agencies. It primarily affects governance procedures and how meetings are defined.	Passed Senate Local Government Committee (6-0 on 4/22/26) Passed Senate Judiciary Committee (12-0 on 5/6/26) Passed the Senate (39-0 on 5/29/26) Referred to the Assembly Local Government Committee (6/11/26) Passed Assembly Local Government Committee (8-0 on 7/1/26)

Advocacy Tracker

Priority	Legislation	Description	Status
2	AB 2386 - Alvarez	Licensed Physicians from Mexico Program Expands California's physician workforce pathways by allowing physicians from Mexico who complete a limited-term program to transition to full licensure and continue practicing in the state. The bill also creates a provisional licensing pathway for internationally trained physicians to practice under supervision and eventually obtain full licensure. It is intended to address physician shortages—particularly in underserved and rural areas—while maintaining oversight and training requirements. Update: The bill was amended to clarify eligibility, supervision, and licensure requirements for internationally trained physicians participating in the provisional licensing pathway.	Passed Assembly Business and Professions Committee (11-2 on 5/1 Passed Assembly Appropriations Committee (11-2 on 5/1 Passed the Assembly (54-9 on 5/26/26) Referred to Senate Business, Professions and Economic Amended in the Senate (6/16/26) Passed Senate Business, Professions and Economic Dev Re-referred to Senate Appropriations Committee (6/22/26 Senate Appropriations Committee hearing scheduled (8/3
2	AB 2497 - Johnson	Physical Therapy Scope of Practice Expansion Modernizes and expands the scope of practice for physical therapists in California. Authorizes physical therapists to perform additional services such as musculoskeletal ultrasound, broader direct access treatment, referrals for imaging, and certain tissue penetration procedures commonly referred to as dry needling. The bill is intended to improve access to musculoskeletal care and reduce administrative barriers, but has generated opposition from acupuncture groups and others concerned about training standards and patient safety. Update: The bill was amended to further define education, competency, and certification requirements for physical therapists performing dry needling and other newly authorized procedures.	Passed Assembly Business and Professions Committee (Passed Assembly Appropriations Committee (15-0 on 5/1 Failed on Assembly Floor (26-19 on 5/28/26)

Advocacy Tracker

Priority	Legislation	Description	Status
2	AB 1460 - Rogers	Pharmacy / 340B Program Prohibits pharmaceutical manufacturers from restricting qualifying nonhospital 340B clinics from using contract pharmacies to dispense discounted medications to eligible patients. The bill is intended to protect access to the federal 340B program and preserve pharmacy-related funding mechanisms used by safety-net and rural healthcare providers. Supporters state the bill protects patient access and operational sustainability, while opponents raise concerns regarding transparency and oversight of contract pharmacy arrangements. Update: Adds annual audit, recertification, and reporting requirements for participating 340B clinics while strengthening protections for the use of contract pharmacies.	Passed Assembly Health Committee (16-0 on 4/8/26) Passed Assembly Appropriations Committee (15-0 on 5/1/26) Passed the Assembly (79-0 on 5/28/26) Referred to Senate Health Committee (6/10/26) Passed Senate Health Committee (11-0 on 6/25/26) Re-referred to Senate Judiciary Committee (6/25/26) Amended in the Senate (6/27/26) Was not heard in Senate Health Committee
3	AB 2729 - Bonta	Employer fee for employees on Medi-Cal Would impose a fee on large employers whose employees rely on Medi-Cal for health coverage. The bill is intended to shift some of the cost burden to employers whose workers depend on public health programs. It aims to support Medi-Cal funding but may increase costs for certain employers. Update: The bill now establishes a framework for implementing the employer fee through the state budget process.	Passed Assembly Health Committee (11-3 on 4/21/26) Re-referred to Assembly Appropriations Committee (4/22/26) Placed on the Assembly Appropriations Suspense File (5/1/26) Amended and re-referred to Assembly Appropriations Committee (5/1/26)

Advocacy Tracker

Priority	Legislation	Description	Status
3	AB 1900 - Kalra	Single payer health system Proposes the establishment of a statewide single-payer health care system in which the state would finance and oversee coverage for all Californians. The bill would significantly restructure how hospitals and providers are paid by replacing much of the current multi-payer system with a state-administered model. While intended to expand access and control costs, it would have major implications for hospital reimbursement, financial sustainability, and operations.	In Rules - Dead for 2026
3	AB 1671 - Tangipa	Creates grant program for providers to serve in rural areas Establishes a grant program to support healthcare providers who commit to serving in rural and underserved areas. The bill is intended to improve workforce recruitment and retention by offering financial incentives to providers. It aims to expand access to care by increasing the availability of healthcare professionals in rural communities.	In Asm Appropriations -Held on Suspense File Dead for 2026
3	AB 2665 - Tangipa	Budget request for Northern and Southern Inyo HCDs a budget request that seeks state funding support specifically for the Northern and Southern Inyo Healthcare Districts. The bill is intended to provide financial resources to sustain operations, infrastructure, or services in these rural districts.	Pulled

Advocacy Tracker			
Priority	Legislation	Description	Status
3	SB 1422 - Durazo	Allows for individuals who are unsatisfactory immigration status to apply for full scope Medi-Cal Expands eligibility for full-scope Medi-Cal to individuals regardless of immigration status. The bill is intended to increase access to comprehensive health coverage for underserved populations. It would likely increase enrollment in Medi-Cal and expand access to care across the healthcare system.	Passed Senate Health Committee (11-0 on 4/9/26) Passed Senate Appropriations Committee (7-0 on 5/23/26) Placed on inactive file in Senate
3	AB 2131 - Rubio	Exclude freestanding structures like congregate living health facilities or hospices from seismic requirements. Exempts certain freestanding health care facilities, such as congregate living health facilities and hospices, from California's hospital seismic safety requirements. The bill is intended to reduce regulatory and financial burdens on these smaller or non-acute care facilities. It recognizes that these facilities may not require the same level of seismic compliance as full acute care hospitals.	In Asm Health - Dead for 2026
3	AB 1018 Bauer-Kahan	Automated Decision Systems Regulates the use of automated decision systems and artificial intelligence tools used in areas such as healthcare, employment, housing, insurance, and public services. The bill would require impact assessments, bias evaluations, transparency disclosures, and certain consumer protections related to AI-assisted decision making. It is intended to address concerns regarding discrimination, accountability, and oversight of AI systems, but may create additional compliance and operational requirements for healthcare organizations and public agencies.	Passed Assembly Privacy and Consumer Protection Committee (10-0 on 4/29/25) Passed Assembly Judiciary Committee (8-3 on 4/29/25) Passed Assembly Appropriations Committee (10-3 on 5/2/25) Passed the Assembly (50-16 on 6/2/25) Referred to the Senate Judiciary Committee (6/11/25) Passed Senate Judiciary Committee (7-2 on 6/26/26) Passed Senate Appropriations Committee (5-2 on 8/29/26) On Senate Floor

Advocacy Tracker

Priority	Legislation	Description	Status
3	AB 1789 - Boerner	Campaign Finance and Ethics Training Requirements Requires most state and local candidates for elected office, as well as certain campaign treasurers, to complete FPPC-approved training on campaign finance and ethics laws. The bill is intended to improve compliance with the Political Reform Act, reduce reporting violations, and increase public confidence in elections. The requirements would likely apply to candidates for local special district boards, including healthcare districts, beginning January 1, 2029.	Passed the Assembly (78-0 on 5/26/26) Passed Senate Elections and Constitutional Amendments Committee (5-0 on 6/16/26) Re-referred to Senate Appropriations Committee (6/16/26) Senate Appropriations Committee - Placed on Suspense File
3	AB 225 Bonta	Facility Fees for Outpatient Services Prohibits hospitals from charging facility fees for telehealth visits, preventive services, and certain outpatient office visits that are commonly provided in hospital-owned clinics. Facility fees are additional charges billed by hospitals, separate from the provider's professional fee, and can represent a significant source of outpatient revenue. Recent amendments would also require hospitals to notify patients when facility fees may be charged and report facility fee revenue and utilization data to the state. The bill could reduce hospital revenue and increase reporting requirements for facilities that rely on outpatient clinic services. Update: The bill was amended to narrow the prohibition on facility fees by exempting certain outpatient services, including emergency, observation, surgery, and diagnostic services. It also clarifies hospital notice requirements and requires annual reporting of facility fee revenue, utilization, and payer information to the state.	Passed Assembly Health Committee (11-4 on 4/8/26) Passed Assembly Appropriations Committee (10-5 on 5/2/26) Passed the Assembly (51-17 on 6/2/26) Referred to the Senate Health Committee (6/16/26) Senate Health Committee hearing scheduled (bill pulled fi

Budget Bill Tracker			
Priority	Legislation	Description	Status
1	AB/SB 165	Skilled Nursing Facility Budget Trailer Bill Implements the 2026–27 State Budget provisions affecting California's skilled nursing facilities by revising Medi-Cal reimbursement and quality incentive programs. The bill suspends the state's 96-hour backup power requirement until funding is appropriated to reimburse facilities for compliance, eliminates future Workforce and Quality Incentive Program (WQIP) payments, and makes technical changes to skilled nursing facility reimbursement.	Passed the Legislature as part of the Enrolled and presented to the Governor Signed by the Governor (6/29/26)
2	AB/SB 164	Health Budget Trailer Bill Implements the healthcare provisions of California's 2026–27 State Budget. The bill includes statutory changes affecting Medi-Cal, HCAI, the Data Exchange Framework, hospital reporting, healthcare workforce initiatives, and numerous operational and technical healthcare programs. It remains under final amendment as part of the budget package and will serve as the primary healthcare implementation bill for the fiscal year.	Passed the Assembly (6/27/26) Passed the Senate (6/27/26) Enrolled and presented to the Governor Signed by the Governor (6/29/26)

Budget Bill Tracker			
Priority	Legislation	Description	Status
2	AB/SB 125	Managed Care Organization (MCO) Tax Renews and restructures California's Managed Care Organization tax to comply with federal Medicaid requirements. The bill preserves billions in federal Medi-Cal funding while shifting more of the tax burden to commercial health plans. Although it is not expected to directly change NIHD's commercial reimbursement rates, it could increase employer health insurance costs and help support future Medi-Cal provider investments. Update: Extends California's Managed Care Organization (MCO) tax through December 31, 2028, preserving a major funding source that supports Medi-Cal and allows California to continue drawing billions in federal Medicaid matching funds.	Passed the Senate (28-10 on 3/20/26) Passed the Assembly (47-19 on 6/1/26) Senate concurred in Assembly amendment Enrolled and presented to the Governor Signed by the Governor (6/27/26)
2	AB/SB 171	Labor Budget Trailer Bill Implements the labor and workforce provisions of California's 2026–27 State Budget, with the most significant changes reforming the Subsequent Injuries Benefits Trust Fund (SIBTF). The bill tightens eligibility for SIBTF benefits, requires stronger documentation of pre-existing disabilities, revises claims administration and appeals procedures, and is intended to slow rising workers' compensation costs for California employers. While it does not create significant new employment mandates for hospitals, it may modestly affect NIHD through changes to the state's workers' compensation system.	Passed the Assembly (6/27/26) Passed the Senate (6/27/26) Enrolled and presented to the Governor Signed by the Governor (6/29/26)

Budget Bill Tracker			
Priority	Legislation	Description	Status
2	AB/SB 177	Fair Share from Big Corporations Act Requires the Department of Finance to develop options for requiring California's largest corporations to contribute toward the public cost of employees enrolled in Medi-Cal. The bill does not immediately affect hospital reimbursement but could influence future Medi-Cal financing and provider funding in later budget cycles.	Passed the Legislature as part of the Enrolled and presented to the Governor Signed by the Governor (6/29/26)
2	SB 122	Digital Prewritten Software Sales Tax Expands California's sales and use tax to apply to prewritten computer software regardless of how it is delivered, including downloaded software and Software-as-a-Service (SaaS), beginning January 1, 2027. The bill redefines digital software as taxable tangible personal property, establishes sourcing rules for remote software purchases, and extends certain business tax credit limitations. The measure is expected to increase software costs for hospitals, healthcare districts, and other public agencies that rely on cloud-based systems for electronic health records, payroll, cybersecurity, finance, credentialing, and other operations. Update: The enacted bill delays implementation until January 1, 2027, expands California sales and use tax to digital prewritten software and Software-as-a-Service (SaaS), and directs the California Department of Tax and Fee Administration (CDTFA) to implement the new requirements through guidance and administration before the tax takes effect.	Passed the Senate Passed the Assembly Senate concurred in Assembly amendments Enrolled and presented to the Governor (6/18/26) Signed by the Governor (6/27/26)



NORTHERN INYO HEALTHCARE DISTRICT NON-CLINICAL POLICY

Title: Media Policy		
Owner: MANAGER OF MARKETING COMM AND STRATEGY		Department: Marketing
Scope: District-wide		
Date Last Modified: 06/30/2026	Last Review Date: No Last Periodic Review Date Set	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

Purpose

This policy establishes guidelines for communication with the media and the public to protect patient privacy, support accurate and consistent public communication, and coordinate media access and response activities.

Scope

This policy applies to the Northern Inyo Healthcare District (NIHD) Board of Directors (“Board”), workforce, and individuals acting on behalf of NIHD, referred to throughout this policy as the District.

All individuals covered under this policy are expected to maintain confidentiality, protect patient privacy, and follow procedures regarding media access, public communications, filming, photography, and the release of information related to District operations.

Definitions

Media: Any organization or individual gathering information for print, broadcast, digital, documentary, podcast, or online publication, including reporters, photographers, bloggers, social media content creators, freelance journalists, or documentary producers.

Protected Health Information (PHI): individually identifiable health information that is transmitted or maintained in any form or medium, including electronic PHI.

Manager of Marketing, Communications, and Strategy: The individual designated by the Chief Executive Officer (CEO) to manage media relations, press inquiries, and public communications on behalf of the District.

Administrator-on-Call (AOC): The on-duty administrator responsible for after-hours operational oversight and initial media coordination during emergencies or incidents of public interest.

Workforce: Persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or who have an executed agreement with NIHD, whether or not NIHD pays them. The workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Advanced Practice Providers (APPs), and other NIHD health care providers involved in the provision of care for NIHD’s patients.

Policy

1. The Manager of Marketing, Communications, and Strategy or designee shall be contacted regarding all media inquiries, interviews, filming requests, photography requests, and requests for public statements related to District operations, patients, incidents, personnel, or other District matters.
2. Individuals covered under this policy shall not release confidential, Protected Health Information (PHI), operational, personnel-related, or other non-public District information without authorization.
3. The District reserves the right to deny, limit, supervise, or discontinue media access or recording activities to protect patient privacy, confidentiality, safety, security, and the delivery of care.
4. Communications related to District business, including certain electronic communications and social media activity, may constitute public records or business records subject to retention, disclosure, litigation hold, audit, or legal review requirements.
5. Nothing in this policy is intended to interfere with or prohibit communications or activities protected by applicable law, including:
 - a) Lawful speech, governance responsibilities, and legally protected communications of elected Board members acting within their official capacities or rights under applicable law.
 - b) Protected whistleblower activity or lawful reporting to governmental agencies.
 - c) Protected concerted activity, discussions regarding wages or working conditions, or other legally protected employee communications.
6. No individual covered under this policy shall make statements on behalf of the District unless authorized.

Procedure

1. Law Enforcement and Government Agency Requests

- a) Requests from law enforcement, governmental agencies, or public officials for information, interviews, recordings, or facility access shall be coordinated through the Chief Executive Officer (CEO), the Chief Operating Officer (COO), the Compliance Officer, Legal Counsel, or other designated personnel as appropriate.

2. Media Inquiries

- a) The Manager of Marketing, Communications, and Strategy shall be contacted during business hours, or the Administrator-on-Call (AOC) after hours, regarding calls, emails, visits, interview requests, or inquiries from reporters, photographers, film crews, social media content creators, or other media representatives to ensure accurate and coordinated communication.
- b) Media interviews of patients, families, workforce members, or visitors on District property require prior authorization from District leadership and any required patient authorization or consent.
- c) The Manager of Marketing, Communications, and Strategy shall serve as the official District spokesperson unless otherwise designated by the Board or District administration.

3. Media Access to District Property

- a) Media representatives must obtain prior approval from the CEO, Manager of Marketing, Communications, and Strategy, or the AOC before entering District facilities for media-related activities. Media representatives are required to check in, wear identification, and remain escorted while on District property.
- b) Media representatives are not permitted in patient-care areas, restricted areas, or staff workspaces without approval and supervision.
- c) Filming, photography, or recording by media representatives is prohibited unless approved by the Manager of Marketing, Communications, and Strategy and supported by appropriate written patient authorization when required. Approved media activities must not disrupt operations, patient care, privacy, safety, or security.
- d) The District may establish designated media staging areas during emergencies or incidents of public interest.

4. Workplace Violence and Security Concerns

- a) The District may immediately suspend or terminate recording, filming, photography, or media access activities that create safety, security, workplace violence, harassment, disruption, or operational concerns.

5. Photography, Videography, and Recordings

- a) The Manager of Marketing, Communications, and Strategy or designee must approve photography, filming, or recording involving patients, patient-care activities, or District operations. Written HIPAA-compliant authorization shall be obtained before photography, filming, or recording involving patients or Protected Health Information unless otherwise permitted by law.
- b) Photography, filming, or recording in public areas of the District, including lobbies, waiting areas, parking lots, or exterior grounds, must not capture patients, Protected Health Information (PHI), confidential information, or activities that compromise privacy, safety, or operations.

6. Release of Patient Information

- a) The Manager of Marketing, Communications, and Strategy shall be contacted regarding requests from the media or public for patient information or condition updates.
- b) Patient information, including a patient's identity, condition, treatment, admission status, or other Protected Health Information (PHI), shall not be released without appropriate authorization or legal authority.
- c) Any permitted disclosure shall be limited to the minimum necessary information consistent with applicable law.

7. After-Hours and Emergency Incidents

- a) The Administrator-on-Call (AOC) shall coordinate media inquiries involving after-hours emergencies, incidents, or events involving heightened public or media interest with the Manager of Marketing, Communications, and Strategy and the CEO. If unavailable, the AOC shall continue notification efforts

through the COO, Chief Human Resources Officer (CHRO), Chief Medical Officer (CMO), and Chief Financial Officer (CFO) as appropriate.

- b) During declared emergencies or incident command activations, media communications may be coordinated through the Hospital Incident Command System (HICS) or other designated emergency management structure.

8. Filming and Recording by Patients, Visitors, or Staff

- a) Patients and visitors may record their own care to the extent permitted by law, provided such recording does not interfere with patient care, compromise privacy or confidentiality, capture other patients, staff or Protected Health Information (PHI), disrupt operations, threaten safety or security, or violate applicable law.
- b) Recording, live-streaming, or broadcasting in shared clinical areas, treatment areas, or restricted areas is prohibited unless authorized by District leadership.
- c) The District may restrict or prohibit recording in clinical, treatment, restricted, or shared-care areas to protect patient privacy, safety, confidentiality, and operational integrity.

9. Social Media

- a) Protected Health Information (PHI), personnel information, proprietary information, and confidential operational information shall not be posted, shared, photographed, recorded, disclosed, or discussed publicly without authorization.
- b) In addition, confidential or non-public information obtained through District or Board activities shall not be posted, shared, photographed, recorded, disclosed, or discussed publicly without authorization.
- c) Board members shall comply with applicable California Brown Act requirements when engaging in electronic communications or social media activity related to District business.
 - i) Board members shall not use social media or electronic communications to
 - (1) discuss District business with one another,
 - (2) respond directly to one another's posts or comments, or
 - (3) Use reactions, emojis, or other digital icons in a manner that may constitute a serial meeting or deliberation outside of a properly noticed public meeting.
- d) Individuals expressing personal opinions regarding District matters should make reasonable efforts to clarify when views are personal and not official District statements.

References:

1. Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, including the Privacy Rule, 45 CFR Parts 160 and 164.
2. Health Information Technology for Economic and Clinical Health (HITECH) Act.
3. California Confidentiality of Medical Information Act (CMIA), California Civil Code §§ 56-56.37.
4. Centers for Medicare & Medicaid Services (CMS) Conditions of Participation, including patient rights, privacy, confidentiality, and medical record requirements, as applicable.

5. Joint Commission Accreditation Standards, including standards related to patient rights, confidentiality, privacy, information management, communication, and leadership.
6. Ralph M. Brown Act, California Government Code §§ 54950 et seq., as applicable.
7. California Public Records Act, California Government Code §§ 7920.000 et seq., as applicable.
8. Section 1557 of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18116, and implementing regulations, 45 CFR Part 92.
9. Americans with Disabilities Act of 1990 (ADA), as amended, 42 U.S.C. §§ 12101 et seq.
10. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794.
11. 42 CFR Part 2 – Confidentiality of Substance Use Disorder Patient Records, as applicable.
12. 42 U.S.C. § 290dd-2 – Confidentiality of Records Relating to Substance Use Disorder Treatment, as applicable.

Cross-Referenced Policies

13. Social Media Policy
14. Minimum Necessary Access, Use, and Disclosure of PHI
15. Using and Disclosing PHI for Treatment, Payment, and Operations
16. Emergency Incident Command

Supersedes: Not Set
